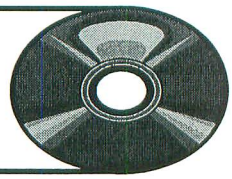
ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

THE NEWSLETTER OF
THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

VOL. 9, No. 4 FALL 1997

Introducing an entirely NEW way to learn!

The Athlete's Knee on CD-ROM



The **Athlete's Knee** makes you an active problem-solver. The program was developed by the American Academy of Orthopaedic Surgeons and centers around 3 real-world case studies. This program was developed by JW Ewing, MD; RS Gruby, MD; and TL Whipple, MD and is being offered to physical therapists through the Orthopaedic Section.

These clinically relevant cases will challenge your knowledge and reasoning ability. Pretest and post-test questions are included with each case study and each answer includes a rationale and reference. The definition of "athlete" is broadly used, encompassing an elderly gentleman with a degenerative knee.

Each case begins with a history. The participant is then required to prioritize the best questions to ask the patient during the subjective interview. Varied point values are given for each question and a rationale and reference as to why one choice is better than another is included. The case then proceeds through examination techniques, radiographs, special studies, dispositions, surgical techniques, and rehabilitation programs.

This CD-ROM is appropriate for the physical therapist. While some of the program is beyond the scope of PT practice, a wealth of information applicable to physical therapy is embedded in each case. Video clips and still photos supplement more than 50 relevant journal articles, abstracts of 100 articles, and excerpts from *Orthopaedic Basic Science*.

Thirty hours of continuing education units (CEUs) are offered through the Orthopaedic Section for participants completing the program.

Level: Intermediate to Advanced

REGISTRATION FEES

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*Absolutely no refunds will be given. Shipping and handling charges of $35 will be added for registrations outside the U.S./Canada.

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☐ I wish to become an Orthopaedic Section Member ($50) and take advantage of the member rate.

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Editor's Note

Duty to Serve

Although I try to maintain a broad perspective on issues facing our profession, it is often difficult to see outside of the box that our local geographic environment paints around us. Those of us in states such as Ohio are still living in the soon-to-be surreal world of fee for service. But a recent lecture to students in Arizona demonstrated how payment structure can drive ethical thinking.

I was teaching about health care malpractice and the students were attentive. The lecture was proceeding smoothly, and I was going through the materials, having reviewed this particular subject many times before. As part of the discussion on "duty," I teach that if you need to terminate the patient/therapist relationship, that you should do so with care, avoiding the possible allegation of abandonment. It was at that point in time that the questions started rolling in. It turns out that Arizona is one of the most managed care inundated states and even senior physical therapy students were concerned with third party limitations on the number of allowed visits. "What if my patient has had their ACL reconstructed and all I'm allowed is six visits?", they asked, "Do I have to offer pro bono treatment?" "What about long-term rehab when only a few visits are certified?"

Although seemingly unrelated, the questions remind me of the recent United States Supreme Court ruling involving notes taken by White House attorneys with regard to the Whitewater investigation. The White House had argued that notes taken by their lawyers based on conversations with the First Lady were protected by the attorney-client privilege. The Supreme Court, in refusing to turn over the lower courts ruling said that the government's lawyers represented the people of the United States, not Hillary Clinton. Law school classes have long been taught that U.S. government lawyers have as their clients the people of the United States. This decision provides insight into the questions posed by the Arizona students. Physical therapists, like the government lawyers, need to remember to whom it is that they owe allegiance. To whom do they owe a duty of care?

Recently, a case manager was upset when I would not update her on the progress of one of my patients. The patient had informed me that she did not want the case manager involved in her care. End of discussion. The patient made a request that I was duty-bound to honor. I encourage my patients to have open lines of communication with their employers and case managers, but the patient still comes first.

I have heard it said that managed care is, in reality, managed *payment*. These are wise words that might help with ethical dilemmas. Physical therapists owe no duty of care to an insurance company, third party administrator, case manager, or referring physician. The only duty we owe is to our patient!

Jonathan M. Coopermann, MS, PT, JD

President's Message

Mirror, Mirror on the Wall

In the fairy tale *Snow White* the wicked stepmother frequently addressed her mirror wanting confirmation that she was indeed the fairest in all of the land. Life was good for the kingdom until the mirror gave the stepmother the bad news that her beauty power rating had slipped a bit. After some tense moments, good does prevail over evil in this particular fairy tale.

This September the Orthopaedic Section's Elected Officers and Committee Chairs will gather in Chicago for the annual Fall Board of Directors meeting. Typically, this meeting has consisted of committee and task force reports and strategic planning for the upcoming year. This year's meeting will be different, being marked by us "addressing" our mirror. Not to be told who is the fairest in the land, because personally I don't want to be reminded where I stand in the beauty power rating. My daily early morning gaze into the bathroom mirror is enough of a reminder. We will look into the mirror to assess who we are as the Orthopaedic Section, what our purpose is, and are we serving the membership in the most effective and efficient fashion. We will revisit the Section's vision. We will also develop a mission statement, as the Orthopaedic Section currently does not have one, and finally we will develop long range strategic plans and objectives.

Our guiding force to this point has been the Section's purpose statement, whose primary focus is provision of services and resources to the membership and a vehicle via which membership can exchange information. Overall, I believe the Section has been successful in terms of provision of such services and resources. Over the past 30 months we have contributed or pledged to contribute $480,000 to orthopaedic physical therapy research efforts and a research mentorship program is in place. Continuing education programming continues to be offered to members with particular investment in the home study course efforts. As the dollars for continuing education continue to shrink, the home study course program has become an increasingly attractive option for membership. *The Journal of Orthopaedic and Sports Physical Therapy* and *Orthopaedic Physical Therapy Practice* continue to be valuable vehicles for the dissemination of information and scientific investigations germane to orthopaedic physical therapy.

Over the past 30 months, the Orthopaedic Section has also embarked upon significant initiatives that do not directly fall within the current purpose statements. Many of these program directives have come from membership. Examples of such initiatives include the development of the Media Spokesperson Network and the Compendium of Manual Therapy Practice and Legislative Issues. Both are designed to assist the APTA and State Chapters when they are confronted with particular legislative and public relations challenges. We are developing these as a resource not only for our members, but also for other organizations within our profession. How better to serve our Section members than to provide a vehicle through which orthopaedic physical therapy can be promoted to the public? How better to serve our members than to provide materials to states embroiled in legislative battles that will impact their ability to practice as they have been trained?

> We will look into the mirror to assess who we are as the Orthopaedic Section, what our purpose is, and are we serving the membership in the most effective and efficient fashion.

We are starting to build bridges between our membership and other components of our professional organization. The stronger our working relationship becomes with these groups, the less duplication of efforts and better utilization of resources will occur, both can only benefit our members and the profession. We are starting to build bridges between our membership and nonphysical therapy organizations as well. An example is that we have had representation the past two years at the Annual American Academy of Family Physicians Meeting.

The message the Section has been getting from membership is that solely being a source of information and materials for them is no longer adequate in order to face the challenges associated with the rapidly changing health care environment. Any additions to our purpose for existence as an organization must be reflected in our vision and mission statement. These documents and the corresponding specific objectives will become the driving force behind Section BOD decisions and allocation of our valuable resources. These documents will also provide membership the means to hold the current and future Section BOD accountable for their actions.

The mirror we gaze into this September in Chicago will double as a crystal ball as we try to predict what lies ahead for us as an organization and a profession. We will not be asking the mirror for confirmation of how good a job we think we are doing, but what we can do to best serve and represent our membership. The ideas generated at this strategic planning meeting will be shared with you in the January issue of *Orthopaedic Physical Therapy Practice* and at the Combined Sections meeting in Boston, February 1998. You will not be handed directives from us, but will be asked to participate in this strategic planning process by providing feedback to us as you have the past 30 months. It is only through this collaborative effort can we succeed as an organization.

William G. Boissonnault, MS, PT
President

From the Section Office

Terri A. DeFlorian, Executive Director

The Finance Committee met at the Section office in La Crosse the end of August. The meeting focused on issues relating to next year's budget. For the first time in many years the Section's proposed expenses for 1998 exceeded the proposed income. The Committee made recommendations for trimming the budget and also put forth an explanation as to why the Section is in this situation, which the Board reviewed during their September meeting. The Committee also met with the Section investment broker, auditor, accountant, and developer/leasing agent.

With the *JOSPT* editorial office move to La Crosse, scheduled for Fall of 1998, the Orthopaedic and Sports Sections have been reviewing floor plan drafts for the space in the Orthopaedic Section office building. These plans should be finalized by the end of this year.

The Section office welcomes Shelia Ness to our publications staff. Shelia is the new Education Assistant in charge of all home study course information and registrations. The Publications Department continues to be extremely busy, and the workload will increase in 1998 with more publications being produced.

The Section has a web page. Tara Fredrickson is our in-house web master, and I encourage you to check us out on the Internet. In addition to information provided on our web page, we also have a member chat board. We have four e-mail addresses within the Section office so please feel free to contact us anytime of the day or night.

A copy of our Combined Sections Meeting 1998 educational programming schedule in Boston is included on page 16. Please start now to make your plans to attend. I look forward to seeing you there.

Currently Available Home Study Courses

95-1: Foot & Ankle
95-2: Wrist & Hand
96-1: Cervical Spine
96-2: Topics in Orthopaedic Physical Therapy Assessment
97-1: Hip & Sacroiliac Joint
97-2: Elbow, Forearm, & Wrist

Upcoming Home Study Courses

98-1: Occupational Health
98-A: Strength & Conditioning Applications in Orthopaedics
98-2: Pharmacology

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Put PT into PrevenTion! (And put Prevention into PT)

By Sharon Potter Anderson, DrPH, PT

"It is time for physical therapists to get into prevention. Physical therapists, like dentists, could see clients before they have problems. ***HMOs benefit when patients stay healthy and physical therapy can save them BIG dollars.*** *Physical therapists are uniquely educated to treat as well as to provide health education, health maintenance, and prevention—professional "one-stop shopping."*

For years physical therapists have noticed people with sagging posture, poor body mechanics, and faulty movement patterns, knowing they were headed for trouble. But have you, like most physical therapists, felt that you must wait to see them until they are referred by a physician? When (and if) they ever reach us for treatment, they have often suffered so long the problems are chronic. Physical therapists wait behind closed doors for individuals to walk painfully in, while the public stands outside waiting for physicians' orders. Because of this arrangement, thousands who might benefit from our unique knowledge have never even heard about physical therapy. All this when the physical therapy profession needs public affirmation to reach our 21st-century goals of physical therapy direct access! Prevention practice could change our professional perspective, change our public image, and give our profession full access to the 50% of healthcare dollars projected to be spent on health, education, and wellness by the year 2006, now only 9 years away. (1)

Public health thinkers and innovative physical therapists have advocated prevention for years (2-7), and now even the public is catching on. Wellness is taking off without us; the public jogs, eats right, and asks questions about how to stay healthy. Meanwhile most physical therapists seem caught in the limited perspective of hands on care and tertiary prevention, helping only after disease and injury strikes. Few physical therapists reach out to the public with accessible musculoskeletal prevention. Too often, we still wait and respond to referrals.

A preventive practice model, such as that used by dentists, would expand physical therapy practice. A pediatric dental practice, for example, may see 30-50 children per day for exam, x-ray, cleaning, education, and pep talks. Most of this effort is performed by hygienists and ancillary personnel. Parents are encouraged to bring children early for checkups, and health plans often cover preventive dentistry to save money later on. Such efforts increase dental revenues by increasing patient volume. Yet a great many patients, failing to prevent, still require major treatment and keep dental professionals busy practicing.

> Prevention practice could change our professional perspective, change our public image and give our profession full access to the 50% of healthcare dollars projected to be spent on health, education, and wellness by the year 2006, now only 9 years away.

Imagine with me: Someone you love is headed toward the edge of a 100-foot cliff. At what point in time could you help them most?

1) Top of the cliff ("Stop! Use the stairs!")

2) Grab shirt tail as they fall

3) Bottom of the cliff (splat)

When I told this story to my students, I asked, "Where is OUR profession in this picture?" There was dead silence in the classroom for several seconds, then someone in the front row whispered, "At the bottom of the cliff!"

Is that where we always want to be, just picking up the pieces? Or could we be more effective in our role as physical therapy professionals if we accepted our responsibility to prevent injury, as well as treat it?

For physical therapists, the cliff story illustrates the three basic kinds of prevention: (2)

1. *Primary prevention* — teaching people who are still well and healthy to prevent injury.
2. *Secondary prevention* — screening people for problems so they can be treated if necessary.
3. *Tertiary prevention* — instruction and care to help patients avoid further injury (conscientious physical therapists have always done this, and here is where physical therapists excel).

Many physical therapists have practiced the way we started in World War I, as physician extenders in the medical model, working hands on with injured and diseased patients. (8) We perform well, add new skills and scientific research, and (laudably) teach tertiary prevention. Yet physical therapists have long been educated above what the healthcare marketplace has allowed us to demonstrate. (3) Although articles on physical therapy preventive activity abound and our members do research to show valid outcomes, **our own professional perspective has been too small** to propel the profession to its logical position of responsibility. With the changes occurring in healthcare today, we have a tremendous opportunity to take leadership in musculoskeletal/physical care. Becoming known for prevention, as well as treatment, would place physical therapists at the cutting edge of wellness. It would elevate our profession in the public eye.

Of all healthcare groups, who really takes responsibility for musculoskeletal care? What professional do you automatically call if you have a problem? Think of this: for skin problems, we call a dermatologist; for teeth, we see a dentist; for thinking, a psychologist; but what profession carries overall responsibility for musculoskeletal care? No one. No one profession clearly claims the area. In public minds, physical therapy simply competes with other groups for hands on care, but some of these groups are ahead of us in marketing their approaches to wellness. With our experience and knowledge of healing, physical therapy should be THE profession to call for safe, medically sound solutions to musculoskeletal/physical problems, even before they are so devastating as to require a physician's assessment.

Changing our public image and our self-image

Consider the physical therapy 2010 goal of direct access. We need to move toward primary care, yet physical therapists are traditionally treatment oriented, not policy-oriented. Prevention can change and enhance physical therapy to a larger professional role, a role with greater responsibility, because prevention (all 3 types) is both direct access and a recognized part of primary care.

Sociologist Arnold Birenbaum (9) discusses how professionals can change their social roles. He calls such change a "collective social mobility project," with members of a profession working together toward a common goal. While an important result of this role change is increased public awareness (and greater visibility boosts demand for services!), (4) a more important change is the profession's own improved self-image. By working cohesively as a proactive "learning organization" (10) our profession can move forward to create our own reality as direct access providers. As recognized leaders of the musculoskeletal field, we could responsibly relegate and delegate, accomplishing musculoskeletal/physical goals for the healthy as well as the ill throughout our country.

New Possibilities for Physical Therapy

HMOs, managed care, and capitation have drastically changed the healthcare scene. In this setting, prevention *maximizes* health and saves healthcare dollars. **Physical therapy professionals can practice primary and secondary prevention in HMOs, saving them a great deal of money**. While other groups can educate and screen, physical therapists willing to assume this role in healthcare would be able to *treat* as well as educate and screen, making physical therapists the equivalent of "professional one-stop shopping." Physical therapists can perform primary, secondary, and tertiary prevention. With an expanded prevention focus in the emerging healthcare setting, physical therapists should find themselves even more in demand than before. We simply need to consider our position and refocus upon marketplace needs. Attempts to remain only fee-for-service in the new situation does not serve our profession well, since marketplace changes move physical therapy from an income based to a cost based service. Examples of physical therapy success has already been demonstrated at Kaiser, the oldest HMO, where physical therapists regularly teach and screen groups as well as treat hands on. Clientele affirm the overall care they receive. This allows them more responsibility for their own health and makes hands-on care available from the same skilled professionals who provided their preventive education.

American Physical Therapy Association (APTA) leaders, recognizing the potential for physical therapy involvement in prevention, recently redefined our practice. Now the APTA's official liability insurance carrier, AON, extends coverage for physical therapy practice in health promotion, fitness, and wellness at no extra cost. A representative from Maginnis also stated coverage for these activities.

In addition to creating a healthier society with less disability, pain, and injury, by increasing education and awareness, we could:

- Raise the visibility of the physical therapy profession.
- Create new opportunities for physical therapists.
- Market physical therapy as a profession and market physical therapy personal skills.
- Help physical therapy compete in the changing healthcare scene.
- Involve physical therapy in direct access and primary care.

Prevention in early physical therapy musculoskeletal care would require no turf stealing battles because our circle of care should involve all three levels of prevention. We have simply not yet accepted responsibility for all three. We have been practicing only the bottom ⅓ of our circle, and the other ⅔ are now creating a vacuum. If we do not accept this responsibility, someone else will.

> With the changes occurring in healthcare today, we have a tremendous opportunity to take leadership in musculoskeletal/physical care. Becoming known for prevention, as well as treatment, would place physical therapists at the cutting edge of wellness. It would elevate our profession in the public eye.

How can physical therapists add *primary* and *secondary prevention* to our practices? We need to consider new models. Here are some ideas:

- Preventive care—why not see your physical therapist twice a year to *prevent* movement disorders?
- Occupational physical therapy, industry—screening for new workers, fitness, body mechanics and workplace training, ergonomics (these areas are already pioneered by physical therapists and well reimbursed).
- HMOs—health maintenance physical therapy; focus upon groups for screening and education.
- Consider the pediatric dental practice model (dentists see 30-50 patients/day for preventive services: x-ray, cleaning, parent pep talks, and education, most services provided by ancillary personnel. Human nature dictates noncompliance by some, so they collect from both prevention and treatment).
- Corporations—fitness, consultation, musculoskeletal testing (as well as hands on care).
- Fitness practices and consultation—geriatric, sports, pediatrics, general (all connected with hands-on care when necessary).
- Schools—educate classrooms of children to avoid injury, posture problems, etc.
- Health fairs, seminars.
- Speaking—local community groups, speakers' clubs. (Why not to lawmakers, insurance carriers, etc?)
- Writing
  - Newspapers, magazines, textbook chapters for schools.
  - Write stories and books: for children, adults, special groups, how-to-books.
- Mass media
  - Radio spots, public service announcements.
  - Talk shows (radio and TV).
- Insurance companies—musculoskeletal screenings and tests.
- Chronic diseases (eg, diabetes, arthritis) — take initiative to consult and treat people earlier on; network and oversee caregivers for periodic consultation with hands on as needed. Instruct lay leaders in exercise programs for chronically ill.
- Join the American Public Health Association to form a "physical therapy" group which can network with public health infrastructure. Further the interests of physical therapists to improve the public's health.

Is this dreaming? I certainly hope not. Primary and secondary prevention would unearth us from the basements of hospitals. We would reach myriads of people earlier on. Because of the gap in service, someone will eventually take responsibility for musculoskeletal/physical health. Which professionals would physical therapists prefer to see fill the musculoskeletal void?

Summary

The prevention trend in public health thinking creates an unprecedented opportunity for growth and direct access for physical therapists or other groups who choose to embrace it. The prospect is profound, offers expanded job market potential, and requires no major turf battles. Because it provides both revolution and evolution, it will create permanent change. Physical therapists as a group simply need to become aware and accept responsibility in the musculoskeletal areas we've always treated. The added prevention dimensions for the public will change our public image as well our self-image. Challenges of reimbursement and compliance can be conquered if we work as a group with our goal of direct access in mind.

Prevention is "in" and it is here to stay. (5,6) Only we, as physical therapists, can decide whether we wish to work synchronously to put **PT** into **PrevenTion**. And to care enough about poor Joe Public to grab him before his body crashes at the bottom of the cliff.

References

1. Jones-Burns M. Seeing your way through to AHIMA's Vision 2006. *J AHIMA*. 1997;68(1):30-33. (Author is executive VP of the ICD-9 code book publishing company.)
2. Rothman J, Levine R. *Prevention Practice: Strategies for Physical Therapy and Occupational Therapy*. Philadelphia, PA: Saunders; 1992.
3. Mathews J. *Practice Issues in Physical Therapy*. Thorofare, NJ: Slack Incorporated; 1989.
4. Leathley M, Stone S. Shared concerns. *Physiotherapy*. 1986; 72(1): 12-13.
5. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. (Summary Report). U.S. Department of Health and Human Services, Public Health Service. DHHS Publication No. (PHS) 91-50213.
6. O'Neil EH. *Health Professions Education for the Future: Schools in Service to the Nation*. San Francisco, CA: Pew Health Professions Commission; 1993.
7. *PT Magazine*. APTA Mission Statement, May, 1996; p. 99.
8. Murphy W. *Healing the Generations*. Lyme, CT: Greenwich Publishing Group, Inc.; 1995.
9. Birenbaum A. *In the Shadow of Medicine: Remaking the Division of Labor in Health Care*. Dix Hills, New York, NY: General Hall, Inc; 1990.
10. Senge P. *The Fifth Discipline*. New York, NY: Currency Double Day; 1990.

Sharon Potter Anderson completed a public health doctorate in 1995. Her dissertation topic,"Attitudes of Physical Therapy Students Toward Primary Prevention" appeared as posters at CSM and national APTA meetings in 1996 as well as the national American Public Health Association. She presented "PT Prevention: Are Physical Therapists Missing the Boat?" as an invited speaker at the 1997 Combined Sections Meeting in Dallas, and is an educator at Loma Linda University, Loma Linda, California. If you're interested in the preventive PT listserv, contact sanderson@sahp. llu. Edu

Getting a Handle on Manual Therapy

Use of a Non-Slip Substance (Dycem) as a Manual Therapy Adjunct

By Brian Miller, PT, OCS

Many manual therapy techniques require a certain level of adhesion or friction between the therapist's hands and the patient's body. Improved friction can optimize the ability to execute a given technique with maximum effectiveness. At times, because of the nature of the patient's or the therapist's skin (eg, slipperiness due to perspiration, skin oils, use of skin lotions, certain inherent tissue qualities, etc), it is difficult to maintain proper skin-to-skin contact. The therapist is then compelled to utilize more muscular effort to compensate for the poor grip. In accordance with the Weber Fechner law, (1) increased effort results in decreased comfort for the patient and decreased tactile and proprioceptive sensitivity for the therapist. I have found certain non-slip substances such as *Dycem™** to be a valuable aid in overcoming this problem.

At times, because of the nature of the patient's or the therapist's skin (eg, slipperiness due to perspiration, skin oils, use of skin lotions, certain inherent tissue qualities, etc), it is difficult to maintain proper skin-to-skin contact.

The company is Dycem Ltd., with headquarters in Bristol, England. Dycem Ltd. has been manufacturing the high tack "Dycem Non-Slip" product for over 30 years. Dycem Non-Slip is a nontoxic, food safe, polyester polymer. Depending on its use and care, the non-slip material will last from 5 - 20 years. Dycem products can be cleaned with soap and water, alcohol wipers, or bactercidal cleaners. The Dycem Non-Slip products include molded pads, thin sheet (reel) material, trays, jar openers, self-adhesive backed strips, and panels, in addition to specific designed items in a range of colors and sizes.

Years ago, when I was performing Cyriax type cervical manipulations, I had a 300 lb. patient with cervical pain who possessed a muscular "bull" neck with almost no discernible occipital protuberance. As a consequence, it was very difficult to properly perform a traction/rotation manipulation technique. I thought of the use of Dycem, due to its non-slip properties, and acquired two circular pads of the substance to obtain a better grip on the patient's occiput and chin. The greatly enhanced grip allowed for easy and effective execution of the technique. I used the Dycem from time to time for these manipulations and for hip joint traction, but I subsequently forgot about using it when I shifted to a different style of manual work.

This past year, in cleaning out a cabinet, I rediscovered the Dycem and began thinking of a patient with whom I was having difficulty performing superficial fascial mobilization. (2) The patient had extremely taut skin that was also very smooth and difficult to adhere to. He had demonstrated a markedly forward shoulder position with restricted horizontal mobility of the clavipectoral superficial fascia and restricted muscle play (3) between the anterior deltoid and pectoralis major. I cut a crescent shaped piece of Dycem that fit the body part I was working on. It worked superbly and achieved a dramatic change in shoulder girdle posture in the patient with little muscular effort or exertion on my part (Figure 1).

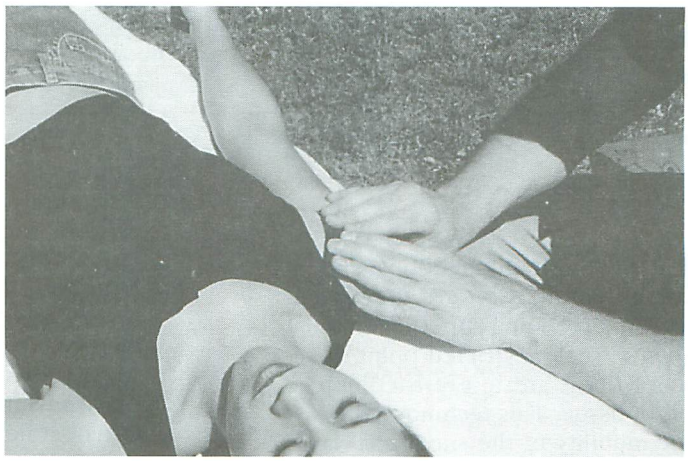


Fig 1. Single contact superficial fascial mobilization to anterior shoulder.

Another area where poor skin traction can be an impediment to proper performance of a manual technique is performing inferior distraction of the sacrum from L5 (Figure 2). This is easy to perform when the lumbosacral angle is sharp, but when the angle is reduced it may be difficult to obtain a secure hold on the sacrum. A square piece of Dycem will greatly facilitate the performance of the technique. Another clinical example involved a patient with adherent scars on her finger secondary to a crush/laceration injury. She was in need of improved superficial fascial mobility for finger flexion. Since her skin was very taut and glassy, mobilization was difficult to perform. The use of Dycem made the mobilization considerably easier.

Techniques requiring a good grip such as those mobilizations advocated by McConnell for medial patellar gliding (5) and thoracic extension (6) and by Mulligan for performing spinal "SNAG" (7) type mobilizations are made much easier with Dycem.

The range of techniques that Dycem can be applied to is limited only by the clini-

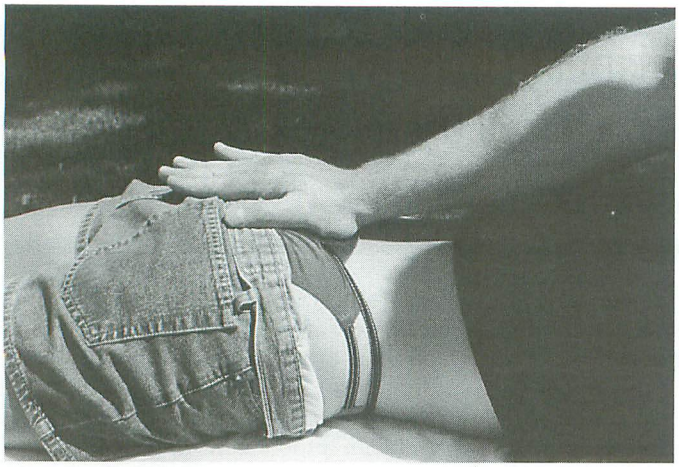


Fig 2. Inferior sacral distractive mobilization.

Fig 3. Dual contact superficial fascial mobilization to posterior cervical.

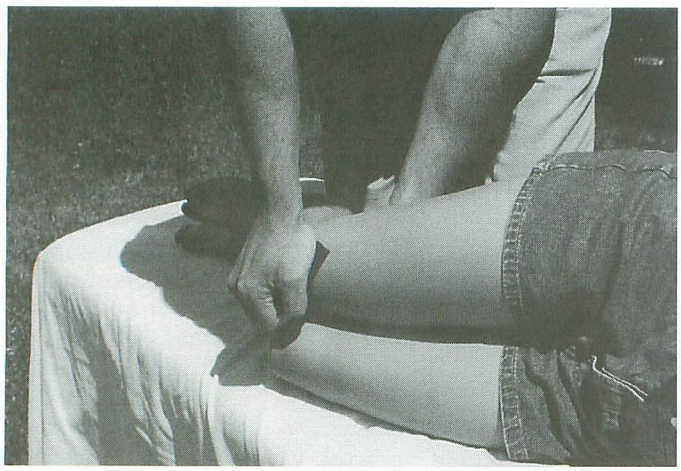


Fig 4. Medial patellar gliding mobilization

cian's imagination and creativity. Both unidirectional and bidirectional superficial fascial mobilization are greatly enhanced by this technique. Unidirectional superficial fascial mobilization involves sliding a single restricted point of superficial fascia in the direction of the greatest restriction relative to the underlying layer of tissue. This technique focuses on improving the extrinsic mobility of the superficial layer relative to the underlying tissue layer. Bidirectional superficial fascial mobilization involves contacting the superficial

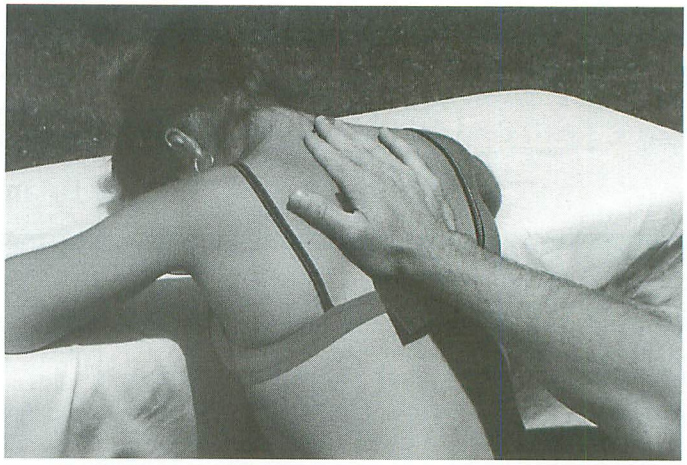


Fig 5. Thoracic extension mobilization.

fascia in two areas of either side of a restricted area of superficial fascia and stretching the area via sliding the two points in opposite directions (Figure 3). This technique focuses upon increasing the intrinsic extensibility of the superficial layer. Various curvilinear and spiraling variations of these techniques are also made much easier by the use of Dycem. Other soft tissue techniques, such as osteopathic myofascial release, (4) that may involve moving larger areas of restricted superficial fascia relative to one another may also be enhanced by the use of this product.

Dycem is equally effective when used with joint mobilization or manipulation. Techniques requiring a good grip such as those mobilizations advocated by McConnell for medial patellar gliding (5) and thoracic extension (6) and by Mulligan for performing spinal "SNAG" (7) type mobilizations are made much easier with Dycem (Figures 4-6). Manipulative techniques such as Mennell's (8) subtalar joint distractive manipulation are also made easier (Figure 7). Almost any form of traction, from cervical and lumbar to finger traction, is facilitated by Dycem (Figure 8).

I've found that having a couple of 4 x 4 inch and 6 x 8 inch sheets of Dycem available allows me to perform the majority of manual techniques that I commonly use in the clinic. The exact size of the Dycem is, of course, dependent upon the size of the therapist's hands. Obviously, it's also necessary to thoroughly wash these sheets between uses, not only for hygienic purposes but also to retain its property of "stickiness." Try this idea if you're having difficulty "getting a handle" on things and you'll be pleasantly surprised by the results.

* Dycem is distributed by the following distributors: Sammons/Preston, Alimed, North Coast Medical, and Smith & Nephew Rolyan.

References

1. Feldenkrais M. *Body and Mature Behavior: A Study of Anxiety, Sex, Gravitation, and Learning*. New York, NY: International Universities Press; 1981.
2. Johnson G. *Functional orthopaedics I continuing education course*. Steamboat Springs, CO: Institute for Physical Art; 1985.
3. Ward R. *Myofascial release continuing education course*. East Lansing, MI: Michigan State University College of Osteopathic Medicine; 1984.

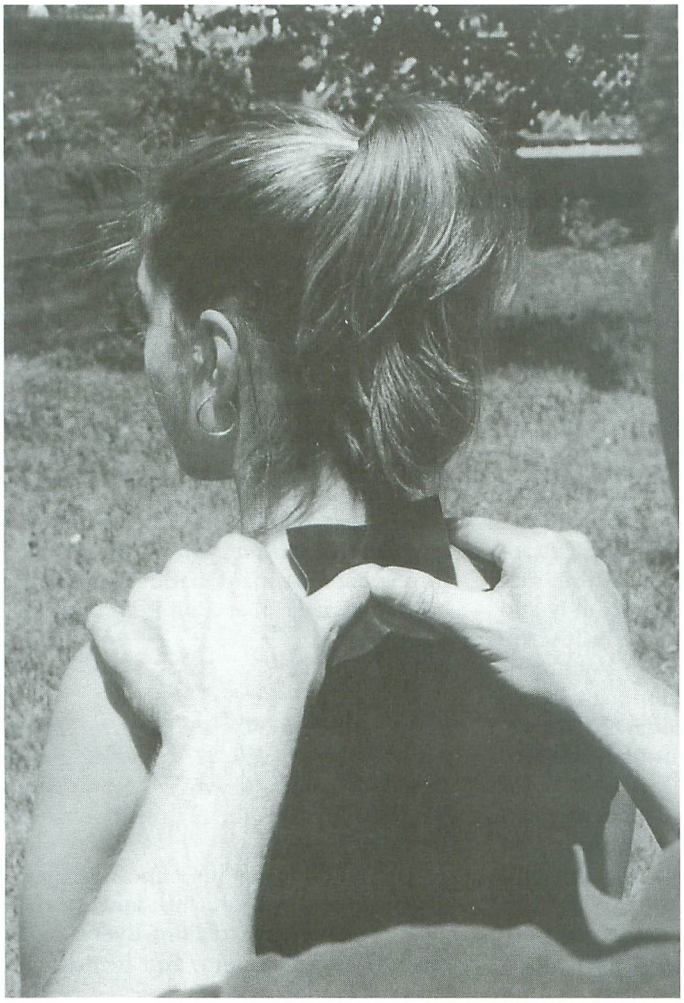


Fig 6. Cervical "SNAG" mobilization.

Fig 7. Subtalar joint distractive mobilization.

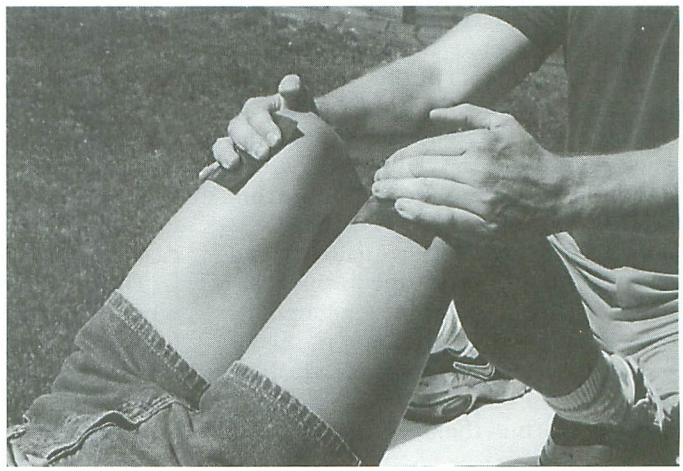


Fig 8. Lumbar 45 - 90 manual traction.

4. McConnell J. *McConnell patellofemoral treatment plan continuing education course*. Marina del Rey, CA: McConnell Institute; 1990.
5. McConnell J. *McConnell approach to the problem shoulder continuing education course*. Marina del Rey, CA: McConnell Institute; 1995.
6. Mulligan BR. *Manual Therapy - NAGs, SNAGs, MWMs, etc, Rvsd. 3rd edition*. 22 Westview Grove, Wellington, New Zealand: Plane View Services Ltd; 1995.
7. Mennell J. *Joint Pain Diagnosis and Treatment Using Manipulative Techniques*. Boston, MA: Little, Brown, and Co; 1964.

Brian Miller, PT, OCS is the co-owner of Community Physical Therapy in Marquette, MI and teaches seminars on integrating alternative and contemporary movement reeducation, therapeutic exercise, and manual therapy concepts. He can be reached at 906-249-9641 or via e-mail at bgmpt@up.net.

Abstracts and Book Reviews

Coordinated by Michael J. Wooden, MS, PT, OCS

D'Ambrogio KJ, Roth GB. *Positional Release Therapy*. St. Louis, MO: Mosby; 1997, 259 pp.

The Assessment and Treatment of Musculoskeletal Dysfunction Using *Positional Release Therapy (PRT)* has evolved from the original text by Lawrence H. Jones, DO known as *Strain and Counterstrain*. The authors describe the new term, PRT as being more broad as it relates to strain/counterstrain (SCS). The contents of the book are divided into eight chapters with an appendix and a glossary. The emphasis of the book is covered in chapter six, which provides treatment procedures from head to toe using PRT. The chapter is divided into the upper quadrant and lower quadrant. Each page in this techniques section includes the tender points (TP), how to find the location of the TP, position of treatment, and both a real life picture and a diagrammatic drawing of the region. Thus, the book is easy to follow.

The first chapter in the text introduces the origins of PRT. It touches on the background of body positioning (shortening and lengthening of structures), tender points, indirect techniques (moving away from resistance), the history of counterstrain, and recent advances. The second chapter discusses the rationale for PRT. The authors acknowledge that this approach is emphasized on soft tissue structures and site studies highlighting myofascia as causing a large majority of musculoskeletal pain and dysfunction.

Chapter three addresses therapeutic decisions when using PRT. The authors define PRT as a method of total body evaluation and treatment using TPs and a position of comfort (POC) to resolve the associated dysfunction. The authors describe the six treatment outcomes using PRT as normalization of muscle hypertonicity, normalization of fascial tension, reduction of joint hypomobility, increased circulation and reduced swelling, decreased pain and increased strength. Emphasis is placed on advancing the patient through four phases of rehabilitation (depending on acuteness of injury), from passive manual therapy and modalities to active exercise and conditioning.

Chapter four discusses the significance of the tender point and characterizes it as a tense, tender, edematous region that is located deep within muscles, tendons, ligaments, fascia, or bone. The authors use a grading scale of sensitivity, a scanning evaluation, and a tender point body chart to determine the treatment plan.

Chapter five contains an overview of the PRT scanning evaluation (SE). The SE identifies TPs for the whole body and ranks them based on severity. A description is presented on how to document the severity in reference to location and sensitivity. This is proceeded by the establishment of a treatment plan and two case studies.

The focus of the text is in chapter six, which is divided into the upper and lower quadrants with evaluation and treatment procedures using PRT. The upper quadrant covers the ornatum, anterior, medial, lateral, and posterior cervical spine, anterior and posterior thoracic spine, anterior, medial, and posterior ribs, shoulder, elbow, wrist, and hand. The lower quadrant includes anterior and posterior lumbar spine, anterior and posterior pelvis and hip, posterior sacrum, knee, ankle, and foot. This detailed chapter is a good reference tool. However, unless the clinician plans to use this treatment technique on a regular basis, the numerous TP's positions, and directions of force can be quite overwhelming. This approach to manual therapy, effective as it may be, would require extensive dedication and time for efficient practical application.

The use of PRT in clinical practice is addressed in chapter seven. The chapter discusses the incorporation of PRT with other modalities, communication with patients regarding the technique, trouble-shooting, treatment using proper ergonomics and body mechanics, and the general considerations of incorporating PRT into clinical practice.

This textbook provides the reader with easily referenced techniques on positional release therapy. I would recommend this book to the clinician interested in another mode of manual therapy, as it is thorough and well organized. I had some trouble following the multiple abbreviations used, and unless the practitioner uses this discipline on a regular basis, the language can be somewhat tedious. I would suggest that the therapist take at least one continuing education course as an adjunct to this book to fully appreciate the method. In addition, clinicians who become proficient in this system that emphasizes treatment of soft tissues as the primary dysfunction, need to respect that many patients may have both a myofascial and joint component.

Cory Tovin, PT

Scott, Ronald W. *Promoting Legal Awareness in Physical and Occupational Therapy*. New York, NY: Mosby; 1996.

The author uses his experience as a physical therapist, educator, and attorney in compiling an excellent overview of business, employment, and health care laws for clinicians.

The organization of the book allows for both in depth study and scanning of issues that are pertinent at any given time in one's practice. The organization of each chapter is outlined in the table of contents. In addition each chapter contains a summary, a case study to promote understanding, suggested answers for the cases, and a reference list, as well as suggested readings.

As an example of format, chapter eight deals with employment law. It advises when to get advice and who may be the best resource. Chapter four is especially helpful in navigating the obligations of clinicians for "informed consent." Issues of liability and insurance laws are informative and answer several questions regarding the obligations for personal and professional actions.

This book would be an excellent addition to a clinical library.

Jill Floberg, PT

APTA News Release

APTA Signs Contract With National Board of Medical Examiner for Specialist Certification Examinations

The American Physical Therapy Association/American Board of Physical Therapy Specialties (APTA/ABPTS) has contracted with the National Board of Medical Examiners (NBME) to develop and administer specialist certification examinations from 1998 through the year 2000.

The physical therapy specialty areas under the new contract are: Geriatric, Neurologic, Pediatric, Orthopaedic, and Sports. Candidates for specialist certification will now take their multiple-choice examinations via computer at any one of a number of Sylvan Testing Centers nationwide.

"The depth of NBME's testing experience, along with the increased number of computerized testing sites, will advance and streamline the testing process," said ABPTS Chairperson Lori Thein Brody, MS, PT, SCS, ATC. "The new testing contract is simply another step forward for the specialization process." APTA/ABPTS will administer written examinations at the APTA Combined Sections Meeting for Cardiopulmonary and Clinical Electrophysiology during this period in order to develop testing methods more conducive to the needs of these specialty areas. "These changes in testing administration are positive ones on all fronts," said Brody. There are currently 2,028 certified specialists nationwide. To obtain specialist certification, physical therapists must demonstrate specialized knowledge and advanced clinical proficiency in one of seven specialty areas: Cardiopulmonary, Clinical Electrophysiologic, Geriatrics, Neurology, Orthopaedics, Pediatrics, and Sports. Candidates must also submit evidence of required clinical practice in the specialty area and successfully complete a rigorous examination. The certificate is valid for 10 years.

The ABPTS, an appointed group of APTA, is responsible for overseeing the physical therapy clinical specialist certification program. The Board awards certificates to physical therapists meeting approved requirements. The mission of the ABPTS is to enhance public health by ensuring clinical excellence in physical therapy practice through credentialing clinical specialists.

NBME offers testing, educational, consulting, and research services for the health professions. It administers examinations for certification, recertification, in-training, self-assessment, or evaluation of special competence to more than 50,000 examinees annually.

If it Says it's a Value Fund and Looks Like a Value Fund, it Must be a Value Fund. Right?

By Fred Fletcher

With careful consideration, we've used a variation of the expression, "if it walks like a duck and quacks like a duck, it must be a duck," to describe a situation all too familiar among mutual funds, but not familiar enough among mutual fund investors.

The mutual fund itself is an interesting animal. Ten years of exploding investor interest has made the mutual fund one of the most preferred methods of funding retirement, preparing for college tuition, and a host of other long-, medium-, and short-term financial objectives.

In fact, from 1985 to 1995, the mutual fund universe increased from 901 to 6,508, while assets in mutual funds increased from $495.5 billion to $2.8 trillion.* The latest tracking numbers from *Morningstar* list more than 8,000 individual funds from which to choose, leaving all but the most accomplished investors with a dizzying number of options.**

Making matters worse is the large number of funds that only loosely adhere to the investment styles under which they bill themselves. An example of this can be found in our headline. Does a mutual fund that has the word "value" in its title, but has a majority of its holdings in growth stocks really qualify as a value fund?

As described by the Linsco/Private Ledger Research Department, the growth and value categories can be defined as follows:

Growth

The fundamental tenet of growth company investing is the belief that the surest way to make capital grow more quickly than average is to identify companies that are capable of sustaining above-average growth and hold on to them. Growth stock managers therefore devote great effort to screening the universe of stocks, focusing on firms demonstrating superior financial characteristics such as rapid growth of sales, earning and dividends, high profit margins, and high returns on invested capital. They willingly pay premium prices to acquire these stocks, in the belief that quality is worth paying for.

Growth stock portfolios are therefore usually characterized by high price/earnings ratios, high price-to-book value ratios, and low dividend yields relative to a market average.

Value

Value investors argue that superior companies don't necessarily mean superior stocks. The key question, in their minds, is not the excellence of a company's products or finances, but the price of its stock in relation to a long-term estimate of its true economic value. Most established growth companies, they will argue, have attractive characteristics that are well understood by investors, and as a result their stock prices usually sell for too high a price in relation to underlying economic value. Better results can be obtained by purchasing companies that are perceived to be of lower quality, but at a much lower valuation.

Value portfolios are, therefore, usually characterized by stocks with low price/earnings ratios, low price-to-book value ratios, and high dividend yields relative to a market average.

So if a mutual fund calls itself a growth or value fund, or by any other name for that matter, why then would its manager deviate from that objective by purchasing investments that clearly do not fit into a particular category? In a word, the answer is "performance." *Morningstar,* the nation's largest mutual fund rating service, along with other rating services, divide funds into categories for the purpose of ranking them against their peers. In an effort to boost performance and stand out from the pack, a manager will buy particular investments that don't necessarily fit into the fund's stated objective. Sometimes this is far less subtle than the manager of a growth stock fund buying value stocks.

Consider the case in 1996 of America's largest mutual fund, Fidelity Magellan. Investors were not at all happy to find out that the manager of this fund, which was billed as an equity fund, had a sizable investment in bonds and cash, considerably dampening returns in a year in which the Dow Jones Industrial Average was up over 26%.***

But, many investors ask, is it really that important if the fund calls itself a value fund if it invests primarily in value stocks? Shouldn't the manager be out looking for "hidden gems" that will help boost overall returns, even if they're outside the stated category of the fund? The answers are yes and no.

The old adage of never putting all your eggs into one basket has never been more important than it is in the investment process. But we believe the best way to spread your investments across many baskets is not by buying funds that are invested outside their investment objectives, but rather by combining funds that are invested according to their stated objectives.

A market that's up over 62% in 2 years can cover up a good deal of sins.**** Not the least of which are mutual funds, referring to themselves as having a certain investment style but being managed according to another.

Our focus is structuring our clients' portfolios to have exposure to a good number of investment categories — so that they are well positioned for good markets and bad. This happens best by finding mutual funds that bill themselves as having a certain style because that's the style they really are.

* Investment Company Institute, February 1997.
** Investment Company Institute, February 1997.
*** Bloomberg, 1996, The Dow Jones Industrial Average (DJA) is an unmanaged index which can not be invested directly into which reflects the overall return attained by a diversified group of 30 stocks of major industrial blue chip companies based in the United States. All returns are calculated with reinvested dividends and expressed U.S. dollar terms. Past performance does not guarantee future performance and your actual results will vary.
**** Bloomberg, 1997. DHA January 1, 1995 December 31, 1996.

Fred Fletcher is an Investment Executive who provides investment advice to the Orthopaedic Section, APTA. If you would like additional information, please contact Fred through the Orthopaedic Section office.

The *Compendium of Manual Therapy Practice and Legislative Issues*

is available free of charge to Orthopaedic Section members. A copy can be obtained from the Orthopaedic Section, APTA, (800-444-3982), APTA's Government Affairs Office (800-999-2782 x 8533), and the American Academy of Orthopaedic Manual Physical Therapists (through Institute of Physical Therapy 800-241-1027).

Please forward any information that would be helpful to other physical therapists and can be added to the compendium to: Elaine Rosen, Orthopaedic Section Office, 2920 East Avenue South, La Crosse, WI 54601. An effort to keep the database current will allow us to better serve APTA members.

1998 CSM PRE-CONFERENCE COURSE
CURRENT CONCEPTS ON TOTAL KNEE ARTHROPLASTY
WEDNESDAY, FEBRUARY 11, 1998

SPONSORED BY THE ORTHOPAEDIC SECTION, APTA, INC.

COURSE OBJECTIVES:

1. Upon participation, the learner will demonstrate knowledge of the disease processes and indications for surgery.
2. The learner will be able to describe surgical techniques and components involved in TKA procedures.
3. After completion, the participants will be able to actively implement a progressive TKA rehabilitation program.
4. Following the course, the clinician will have demonstrated effective hands-on skills to gain the desired outcomes for total knee patients.

SPEAKERS:
Carlton G. Savory, MD, FACS
Mark Baker, PT

Time: 8:00 AM - 5:00 PM with a one-hour lunch
Course Fees:

	12/19/97	1/16/98
Orthopaedic Section PT Member:	$125	$150
APTA PT Member:	$175	$200
PT Non-Member:	$200	$225
Orthopaedic Section PTA Member:	$75	$100
APTA and Non-APTA PTA:	$100	$125

Feel free to contact APTA directly at: 800/999-2782 x 3225 for more details or to register!

Orthopaedic 1998 Tentative Feb 11-15,

❋ WEDNESDAY, February 11, 1998

8:00-5:00
Current Concepts in Total Knee Arthroplasty

❋ THURSDAY, February 12, 1998

8:00-12:00
Multi-Section Program
A Guide to Physical Therapist Practice, Part II: Preferred Practice Patterns

12:30-3:30
Oncology for the Rehabilitation Professional
Joint program with Oncology Section

1:00-2:00
Educating for Meaningful Health Care Practice
Joint program with Education Section

1:00-4:30
Legal and Ethical Concerns in Orthopaedics
Jonathan Cooperman, MS, PT, JD
Ron Scott, JD, PT, OCS

1:00-3:00
Application of Practice Parameters to Patients with Musculoskeletal Pathology
Joint program with Sports Section

1:00-4:20
Research Platforms

3:30-4:30
Update on OCS Certification and Recertification
Jean Bryant, PhD, PT, OCS
Joe Godges, MPT, OCS
Bill O'Grady, MS, PT, OCS, MTC

4:30-6:30
Unopposed Exhibit Hall Break

❋ FRIDAY, February 13, 1998

8:00-10:00
Orthopaedic Section Board & Committee Chair Meeting

3:30-8:30
Orthopaedic Section Board & Committee Chair Meeting Continued

8:00-10:00 & 11:00-1:00
Research Platforms

8:00-12:30
Upper Quadrant Evaluation and Treatment of the Musician
Joint program: Performing Arts SIG and Hand Section
Moderator: Marshall Hagins, MA, PT

8:00-8:30
Epidemiology of Upper Quadrant Injuries in the Musician
Brent Anderson, PT, OCS

8:30-9:15
On-site Evaluation and Treatment of Two Musicians
Jeff Stenback, PT, OCS

9:15-10:00
Ulnar Neuropathy in the Musician
Michael Charness, MD

10:00-11:00
Exhibit Hall Break

11:00-11:45
Treating the Neural Consequences of Repetition in Musicians and Keyboard Users
Nancy Byl, PT, PhD

11:45-12:30
Case Study Presentation Panel

8:00-10:00
Functional Outcomes in Chronic Pain Management
Pain Management SIG Programming
Moderator: Joe Kleinkort, MA, PhD, PT
Speakers: Harriet Wittinik, MS, PT, OCS
Anita Wagner, PharmD, Diane Cynn

8:00-10:00 & 11:00-12:00
Practical Rehabilitation of the Knee for the Physical Therapist Assistant
Joint program with Sports Section Knee SIG
Moderator:
Gary Shankman, OPA-C, PTA, ATC
Speakers: Jeff Konin, MEd, ATC, MPT
Terry Trundle, PTA, ATC

8:00-10:00
Case Management and the Physical Therapist
Joint program with Community Health Section

10:00-11:00
Exhibit Hall Break

11:00-12:00
Foot and Ankle SIG Practice Committee Workshop
Joseph Tomaro, MS, PT, ATC

11:00-2:30
Occupational Health SIG Programming

11:00-12:00
Hot Topics Forum: Status on Ergonomic Regulatory/Certification Issues
Moderator: Gwen Parrott, PT
Speakers:
Susan Isernhagen, PT
Joanette Alpert, MS, PT, CIE, CPE
Scott Minor, PhD, PT

1:00-2:30
Diversifying your Industrial Physical Therapy Practice
Speakers: Steve Crandall, PT, OCS
Stephen Hunter, PT, OCS

1:00-2:30
Performing Arts SIG Research Workshop

1:00-2:30
Single Subject Research Design and Options for Data Analysis and Manuscript Preparation
Speakers: Nancy Byl, PT, PhD
Jennifer Gamboa, MPT
Phyllis Browne, PT
Robert Turner, PT

2:30-3:30
Exhibit Hall Break

1:00-5:30
Foot and Ankle SIG Programming

1:00-2:30
The Hallux-First Metatarsal: Kinematic Analysis and Treatment

Section CSM Boston Schedule 1998

Speakers: Deborah Nawoczenski, PhD, PT
Judith Baumhauer, MD

2:30-3:30
Exhibit Hall Break

1:00-5:30
Foot and Ankle SIG Programming (cont.)

3:30-4:10
Foot and Ankle Nerve Entrapments: Unusual Clinical Presentations
Speaker: Mike O'Donnell, DPT, OCS

4:10-4:50
Sinus Tarsi Syndrome: a Misdiagnosed Foot Pathology
Speaker: Steve Baitch, PT

4:50-5:30
Achilles Tendon Repair: Traditional Postoperative Management vs. Early Motion
Jim Zachazewski, MS, PT, ATC, SCS
Jane Gruber, PT, OCS

1:00-2:30 & 3:30-5:00
Shoulders & Breathing: More Linked than you Think
Joint program with Cardiopulmonary Section
Speaker: Mary Massery

1:00-2:30 & 3:30 - 5:00
The Lumbar Spine and its Influence on Pelvic Dysfunction
Joint program with Section on Women's Health
Speaker: Mark Bookhout

3:30-5:00
Neck Problems in Patient with Vestibular Dysfunction
Joint program with Neurology Section
Speaker: Patricia Winkler

7:00-9:00
Performing Arts SIG Reception

❋ SATURDAY, February 14, 1998

8:00-10:00
Orthopaedic Section Business Meeting

10:00-12:00
Unopposed Exhibit Hall Break

12:00- 1:00
Post Board of Directors Luncheon Meeting

12:30-2:00
Occupational Health SIG Business Meeting

12:30-1:30
Manual Therapy Roundtable Business Meeting
Pain Management SIG Business Meeting
Performing Arts SIG Business Meeting
Veterinary PT Informational Meeting
Foot and Ankle SIG Business Meeting

2:00-5:20
Research Platforms

2:00-5:00
Manual Therapy Roundtable Programming
Manual Therapy Exercise Strategies for Acute Low Back Pain
Moderator: Laurie Kenny, PT, OCS
Speakers: John Olson, MA, PT, OCS
Jim Rivard, PT, MOMT

2:00-5:30
Foot and Ankle Problems of Dancers
Performing Arts SIG and Foot and Ankle SIG Programming
Moderator: Marshall Hagins, MA, PT

2:00-2:15
Introduction to Occupational Stressors of the Dancer
Speaker: Marshall Hagins, MA, PT

2:15-3:00
Epidemiology and Assessment of Foot and Ankle Injuries to Dancers
Speaker: Jennifer Gamboa, MPT

3:00-4:00
Treatment of Foot and Ankle Injuries of Dancers
Speaker: Lynn Medoff, MA, MPT

4:00-4:45
Orthopaedic Evaluation & Surgical Treatment of Foot and Ankle Injuries of Dancers
Speaker: Lew Schon, MD

4:45-5:30
Case Study Presentation

2:00-5:00
Veterinary Physical Therapy: How to Get Started
Moderator: Lin McGonagle, PT, BS Animal Sci
Speakers: Lin McGonagle, PT
Jane Avery, PT, CVT
David Levine, PhD, PT
Leslie Kerfoot, PT, Pres. of Chap

6:00-7:00
Paris Award Lecture

7:00-10:00
Black Tie and Roses

❋ SUNDAY, February 15, 1998

8:30-10:30
Eccentric Control of Movement: Relevance to Orthopaedics and Neurology
Joint Program with Neurology and Clinical Electrophysiology
Moderator: Lola Rosenbaum, PT, OCS
Speaker: Mark Trimble, PhD, PT, OCS

8:30-12:30
Nonoperative and Operative Management of Adolescent Idiopathic Scoliosis
Joint program with Pediatric Section

8:00-12:00
OHSIG Board Meeting

Public Relations Report

The Sponsor-a-Student Program has now matched 58 students to a physical therapist willing to pay their one year membership ($15.00) in the Orthopaedic Section. One hundred and thirty students and six sponsors are yet unmatched. The unmatched sponsors are individuals who expressed a desire to only sponsor a student from a particular program. Don't forget, if you sponsor five students, you are eligible for a free home study course!

The Section has started the process of implementing "Career Starter Dues." This option for students will hopefully be in place by 1999.

The Media Spokesperson Network (MSN) has grown to a total of 124 spokespersons. We have twenty-four remaining media markets to obtain a spokesperson for. Please contact me or the Section office if you would like to serve on the MSN.

Please contact me with any feedback regarding the MSN, or any of our public relations programs.

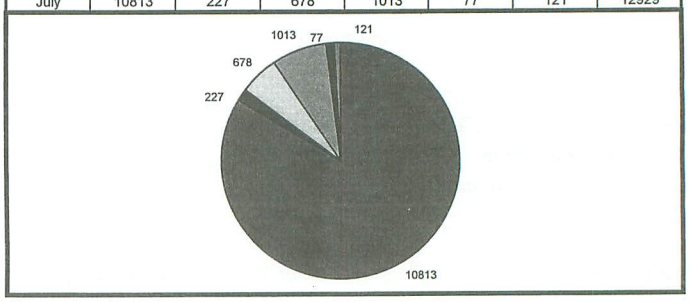
Mari Bosworth, PT
Chair, Public Relations Committee

Membership Report

ORTHOPAEDIC SECTION, APTA, INC.
MEMBERSHIP STATUS

Totals as of July 1997

	Physical Therapists	Physical Therapy Life Members	Physical Therapist Assistants	Physical Therapy Students	Physical Therapy Graduate Students	Physical Therapist Assistant Students	Total
January	10760	204	631	1196	73	166	13030
February	10797	205	633	1263	81	177	13156
March	10797	207	648	1293	85	185	13215
April	10797	211	667	1301	85	184	13245
May	10797	225	730	1214	83	169	13218
June	10797	226	688	1058	131	79	12979
July	10813	227	678	1013	77	121	12929



*Pie denotes July's figures

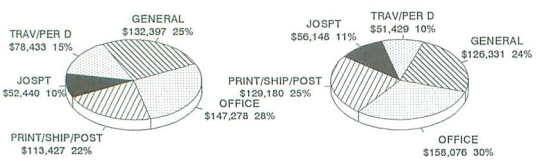
Financial Committee Report

ORTHOPAEDIC SECTION, APTA, INC.
BUDGET TO ACTUAL JUNE 30, 1997
INCOME: BREAKDOWN

BUDGETED $534,695.40 ACTUAL $673,043.87

(+25.87% over our expected budget)

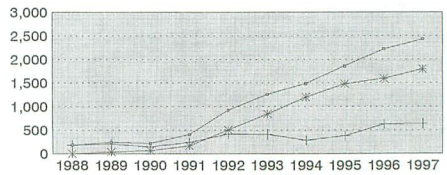
ORTHOPAEDIC SECTION, APTA, INC.
BUDGET TO ACTUAL June 30, 1997
EXPENSE: BREAKDOWN



BUDGETED $523,974.90 **ACTUAL $521,163.67**

(-.54% under our expected budget)

ORTHOPAEDIC SECTION, INC.
YEAR END FISCAL TRENDS FROM 1988-1997
1997 DATA IS AS OF JUNE 30, 1997

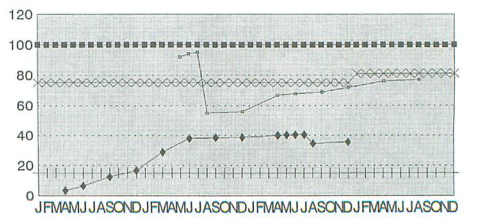


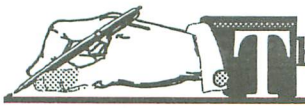
	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
ASSETS	185	243	217	410	925	1,257	1,484	1,858	2,224	2,434
LIABILITIES	183	203	148	240	417	413	283	382	629	640
EQUITY	2	40	69	170	508	844	1,201	1,477	1,595	1,794

ASSETS LIABILITIES EQUITY

To nearest thousand

ORTHOPAEDIC SECTION, APTA, INC.
RESERVE FUND
JAN. 1, 1994 to JUNE 30, 1997





The Orthopaedic Section, APTA Home Study Course 98-1

Occupational Health

Course Length: 6 Manuscripts

January - June 1998

PROPOSED TOPICS & AUTHORS

The Science of Ergonomics
Mark Anderson, MA, PT, CPE
Consulting with Business and Industry
Joanette Alpert, MS, PT, CIE, CPE
Clinical Management of the Injured Worker
Linda Darphin, PT
Marketing and Contracting for On-site Physical Therapy
Roberta Kayser, PT, Stephen Hunter, PT, Steven Crandall, PT
Functional Capacity Evaluation
Ed Barnhard, PT
Issues in Employment Testing and the ADA
Sue Patenaude, MA, PT, CIE

OVERALL COURSE OBJECTIVE

This comprehensive course includes current topics in occupational health, such as the application of ergonomics, job analysis, FCE development and implementation, legal ramifications of employment testing, and measurement and the ADA. Learn what physical therapists can offer industry and how to market those services. Also gain an in-depth understanding of techniques for treating the injured worker and how to successfully manage a work rehabilitation program. Participants will acquire a wealth of resources including didactic references, internet contacts, product manufacturers, professional organizations, and OSHA and ANSI standards and regulations.

EDUCATIONAL CREDIT

Educational Credit: 30 contact hours. A certificate of completion will be awarded to participants who successfully complete the final test. Only the registrant named will obtain the CEUs. No exceptions will be made.

- **Subject Code:** Orthopaedics
- **Instructional Level:** Various
- **EDITOR:** Carolyn Wadsworth, MS, PT, CHT, OCS

REGISTRATION FEES

Register by November 28, 1997. Limited supply available after this date.

$150 Orthopaedic Section Members $225 APTA Members $300 Non-APTA Members

*If notification of cancellation is received in writing prior to the course, the registration fee will be refunded, less a 20% administration fee. ****Absolutely no refunds will be given after the start of the course!**** Special discounted rates are available for institutions with multiple registrants. Please call the Section office for complete information.

ADDITIONAL QUESTIONS: 1-800-444-3982 x 213

98-1 REGISTRATION FORM

Name _____ Title _____

(For clarity, please enclose a business card.)

Mailing Address _____

City _____ State _____ Zip _____

Daytime Telephone (_____)_____ APTA # _____

Please check: ☐ Orthopaedic Section Member ☐ APTA Member ☐ Non-APTA Member

☐ I wish to become an Orthopaedic Section Member ($50) and take advantage of the member rate.

Mail registration and check made payable to:
Orthopaedic Section, APTA, 2920 East Avenue South, La Crosse, WI 54601.
FAX your registration with Visa or MasterCard number to: 608/788-3965.

First 500 registrants will receive an Orthopaedic Section logo business card holder.

Visa / MasterCard (circle one) #: _____ Expiration Date: _____

Signature: _____

OP

CALL FOR NOMINATIONS
APTA SPECIAL AWARDS

Mary McMillan Scholarship: Honors outstanding physical therapy students.

Dorothy E. Baethke - Eleanor J. Carlin Award for Teaching Excellence: Acknowledges dedication and excellence in teaching in physical therapy.

Signe Brummstrom: Acknowledges individuals who have made significant contributions to physical therapy.

Award for Excellence in Clinical Teaching: Acknowledges individuals who have made significant contributions to physical therapy clinical education through excellence in clinical teaching.

Catherine Worthingham Fellows of the APTA: Recognizes those persons whose work has resulted in lasting and significant advances in the science, education, and practice of the profession of physical therapy.

Henry O. Kendall and Florence P. Kendall Award for Outstanding Achievement in Clinical Practice: Acknowledges contributions to physical therapy in general (must have engaged in extensive clinical practice at least fifteen years).

Marion Williams Award for Research in Physical Therapy: Given for sustained and outstanding basic, clinical, or educational research.

Lucy Blair Service Award: Acknowledges members whose contributions to the Association have been of exceptional value.

Mary McMillan Lecture Award: Honors a member of the Association who has made a distinguished contribution to the profession; through a lecture presented at Annual Conference.

Minority Achievement Award: Recognizes continuous achievement by an entry-level accredited physical therapy program in the recruitment, admission, retention, and graduation of minority students.

Minority Initiatives Award: Recognizes the efforts of a physical therapy program in the initiation and/or improvement of recruitment, admission, retention, and graduation of minority students.

Chapter Award for Minority Enhancement: Acknowledges exceptionally valuable contributions to an APTA chapter to the profession relative to minority representation and participation.

Margaret L. Moore Award for Outstanding New Academic Faculty Member: To acknowledge an outstanding new faculty member who is pursuing a career as an academician and has demonstrated excellence in research and teaching.

Helen J. Hislop Award for Outstanding Contributions to Professional Literature: To acknowledge individual physical therapists who have made significant contributions to the literature in physical therapy or in other health care disciplines.

Jack Walker Award: In honor of the contributions made to physical therapy by Jack Walker, former President of Chattanooga Pharmaceutical Company (now the Chattanooga Corp), this corporation has funded an annual award of $1,000 for the best article on clinical practice published in *Physical Therapy.*

Golden Pen Award: Gives recognition to members who have made significant contributions to the advancement of physical therapy.

Eugene Michels New Investigator Award: This is a $1,000 incentive award to encourage continued research efforts in physical therapy.

Chattanooga Research Award: In order to encourage the publication of outstanding physical therapy clinical research reports, the Chattanooga Corporation has funded an annual award of $1,000 for the best article on clinical research published in *Physical Therapy*.

Dorothy Briggs Memorial Scientific Inquiry Award: To give public recognition to physical therapist members of the APTA for outstanding reports of research in physical therapy, undertaken while they were students and published in the official journal of the APTA.

Space limitations do not permit a complete description of awards and scholarships, or the complete criteria. If you desire additional information, please contact the Section office.

Send your recommendations/nominations by December 1, 1997 to:

Orthopaedic Section, APTA, Inc.
2920 East Avenue South
La Crosse, WI 54601
(800) 444-3982

Contacting APTA Staff

1111 North Fairfax Street • Alexandria, VA 22314-1488
Phone: 703/684-APTA • Toll-Free: 800/999-2782
http://www.apta.org
TDD: 703/683-6748 • Fax: 703/684-7343

Accreditation
For information on accreditation activities for PT and PTA education programs
E-mail: accreditation@apta.org
Phone: 800/999-2782, ext 3245

Certification
For information on physical therapy specialist certification
E-mail: spec-cert@apta.org
Phone: 800/999-2782, ext 8520

Chapters, Sections, and Assemblies
For information on state chapters, specialty sections, and assemblies (components)
E-mail: components@apta.org
Phone: 800/999-2782, ext 3234

Continuing Education/Professional Development
For information on Continuing Education programs and APTA's annual scientific meeting and exposition
E-mail: profdevelop@apta.org
Phone: 800/999-2782, ext 3206

Education
For information on PT and PTA education programs and clinical education
Phone: 800/999-2782, ext 3203

Governance
For information on the organization of APTA, including the Board of Directors and the House of Delegates
E-mail: governance@apta.org
Phone: 800/999-2782, ext 3392

Government Affairs
For information on legislative and regulatory issues at the state and national levels
E-mail: govtaffair@apta.org
Phone: 800/999-2782, ext 3164

International Affairs
For information on international issues in physical therapy
E-mail: min-intl@apta.org
Phone: 800/999-2782, ext 8560

Membership Benefits
For information on APTA financial and insurance services
E-mail: Insurance-Benefit@apta.org
Phone: 800/999-2782, ext 3146

Membership Services
For information on APTA membership
E-mail: svcctr@apta.org
Phone: 800/999-2782, ext 3124

Minority Affairs
For information on issues related to racial and ethnic minorities in the PT profession
E-mail: min-int@apta.org
Phone: 800/999-2782, ext 8560

Practice
For information, analysis, advocacy on PT practice, health policy, and clinical standards
E-mail: practice-dept@apta.org
Phone: 800/999-2782, ext 3176

Publications
For content information on APTA periodicals and books

Physical Therapy (Journal)
E-mail: jreynolds@apta.org
Phone: 800/999-2782, ext 3194

PT Magazine
E-mail: ewoods@apta.org
Phone: 800/999-2782, ext 3194

PT Bulletin
Phone: 703/548-5482

Resource Catalog
E-mail: svcctr@apta.org
Phone: 800/999-2782, ext 3395

Reimbursement
For information on private insurer payment, managed care, coding, etc.
E-mail: reimbursement@apta.org
Phone: 800/999-2782, ext 8511

Research Information
For information on research, funding and opportunities, and awards to PT researchers
E-mail: ablake@apta.org
Phone: 800/999-2782, ext 8555

Research Services
For information on surveys and other data collection and analysis related to physical therapy
E-mail: mgoldstein@apta.org
Phone: 800/999-2782, ext 3208

Paris Distinguished Service Award

PURPOSE

1. To acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value.
2. To provide an opportunity for the recipient to share his or her achievements and ideas with the membership through a lecture presented at an APTA Combined Sections Meeting.

ELIGIBILITY

1. The nominee must be a member of the Orthopaedic Section, APTA, Inc., who has made a distinguished contribution to the Section.
2. Members of the Executive Committee and members of the Awards Committee shall not be eligible for the award during their term of office.

CRITERIA FOR SELECTION

1. The Nominee shall have made substantial contributions to the Section in one or more of the following areas:
   a. Demonstrated prominent leadership in advancing the interests and objectives of the Section.
   b. Obtained professional recognition and respect for the Section's achievements.
   c. Advanced public awareness of orthopaedic physical therapy.
   d. Served as an accomplished role model, and provided incentive for other members to reach their highest potential.
   e. Utilized notable talents in writing, teaching, research, administration, and/or clinical practice to assist the Section and its membership in achieving their goals.
2. The nominee shall possess the ability to present a keynote lecture, as evidenced by:
   a. Acknowledged skills in the organization and presentation of written and oral communications of substantial length.
   b. Background and knowledge sufficient.

PROCEDURE FOR NOMINATION

1. Any member of the Orthopaedic Section may nominate candidates for the Award.
2. One original set and four duplicates of all materials submitted for each nomination must be received by the Executive Director at the Section office by December 1, for consideration for the award in the following year.
3. The materials submitted for each nomination shall include the following:
   a. One support statement from the nominator, indicating reasons for the nomination, and clarifying the relationship between the nominator and nominee.
   b. Support statements from two professional colleagues.
   c. Support statement from two former or current Orthopaedic Section officers or committee chairs.
   d. The nominee's curriculum vitae.
4. The nomination materials should document examples of how the nominee fulfills the criteria for this award.

PROCEDURE FOR REVIEW AND SELECTION

1. Nomination materials shall be submitted to the Section office. The Section office will retain the original set of materials and will provide the Awards Committee with copies for review.
2. The Awards Committee will review the nominations and recommend the most qualified candidate to the Executive Committee.
3. The Executive Committee will select the recipient.
4. Any member of the Awards or Executive Committees, who is closely associated with the nominee, will abstain from participating in the review and selection process.
5. The award will be presented only if there are qualified candidates, and one is selected.
6. Nomination materials are considered the property of the Awards Committee, who will maintain their confidentiality.
7. Nomination materials will not be returned. If any individual is not selected for the award in a given year, that individual may be nominated in subsequent years. The Section office will retain nomination materials for two years.

LECTURE

1. The recipient will present their lecture at a Section "Awards Session" at the APTA Combined Sections Meeting. The lecture should not last longer than thirty minutes.
2. The title of the lecture will be left to the discretion of the recipient.
3. The lecture should focus on the recipient's ideas and contributions to the Section and orthopaedic physical therapy.
4. The recipient is invited to submit a paper based on the lecture for consideration for publication (pending review) in the *Journal of Orthopaedic and Sports Physical Therapy* OR submit the paper for publication in *Orthopaedic Physical Therapy Practice.*

NOTIFICATION OF THE AWARD

1. The President of the Section will notify the recipient by April 1st and obtain written confirmation of acceptance by May 1st.
2. The name of the recipient will be kept confidential until announced at the APTA Annual Conference.
3. The award will be presented at the APTA Combined Sections Meeting following presentation of the lecture.
4. Those nominees not selected will be so informed in writing.
5. The nominators or individuals not selected will receive a letter thanking them for their participation and informing them of the award recipient.

THE AWARD AND ITS PRESENTATION

1. The Orthopaedic Section will reimburse the recipient for round trip coach airfare from any site in the US. or Canada to the Combined Sections Meeting at which the lecture is presented, two days per diem consistent with the Section's current reimbursement rates and one day's conference registration.
2. On the occasion of the presentation of the lecture, the awardee will receive an appropriate plaque and an honorarium of $250.
3. The recipient's name and date of award will also be inscribed on a Distinguished Service Lecture Award plaque that is retained and displayed in the Section's headquarters.

Please submit any nominations to the Section office by December 1, 1997.

Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Fall 1997 Volume 4, Number 4

Expand Your Employment And Business Opportunity With Occupational Health

Occupational Health Special Interest Group Education Committee Report

By now everyone has heard about the Vector Workforce Study, the future oversupply of physical therapists, diminishing employment opportunities, and doom and gloom. Ten years ago we never thought we would have to look to other areas to create jobs for ourselves. The time has come when it is necessary to diversify and expand the physical therapy practice into other realms. The practice of occupational health, industrial consultation, and ergonomics has been well served by talented physical therapists for many years. Now more and more therapists are returning to school to earn graduate degrees in engineering, while others turn to continuing education courses to develop their expertise.

The field of occupational health, industrial consulting, and ergonomics is growing and opportunities are abundant. The Occupational Health PT Special Interest Group is committed to assisting our members to expand their knowledge in these areas in order to fill these needs. Our primary goal is to provide continuing educational opportunities for our members. Not only do we provide the occupational health programming at CSM, but hope to plan an independent continuing education seminar in the future. We are also investigating the curriculum content in occupational health in physical therapy and physical therapy assistant degree programs throughout the country. This will enable us to anticipate the future of the educational needs of our profession, as well as be a resource to programs to determine the occupational health curriculum program. In addition, we recently assisted the Orthopaedic Section in outlining the content needs and recommending authors for the upcoming home study program in occupational health.

The OHPTSIG Education Committee maintains a database of potential speakers on occupational health and ergonomics topics of interest. Occasionally we get requests for our database from state chapters and others trying to plan seminars. We are in the process of updating our database. If you or someone you know has expertise in occupational health, consulting, or ergonomics, or any other related fields and would like to be included in our database, please fax the following information to (502) 493-8182:

Your name and credentials, address, home, work, and fax numbers, and topics you have expertise in and would be willing to speak about.

If your chapter or company is looking for a speaker and you would like to receive a copy of our database, please contact:

Gwen Parrott, PT, OCS, OHPTSIG Education Chair, (502) 493-0031 or fax (502) 493-8182.

If you have any recommendations on how the Education Committee can better meet the needs of our members or have any suggestions on future programming, please contact Gwen.

The Education Committee has been busy planning the speakers and topics for CSM '98. The OHPTSIG will sponsor the following:

"Diversifying Your Industrial Physical Therapy Practice"

Speakers: Stephen Hunter, PT, OCS and Steve Crandall, PT, OCS

Hot Topics Forum: "Status on Ergonomic Regulatory/ Certification Issues"

Panelists will include: Scott Minor, PhD, PT; Joanette Alpert, MS, PT, CIE, CPE; and Susan Isernhagan, PT. The discussion will include updates on the BCPE certification issues, status on the Federal OSHA Ergonomic Standard and the new California OSHA regulations.

The topics and authors for the Orthopaedic Home Study course on Occupational Health PT have been determined. Look for this home study program to be released in 1998.

CONTENTS

Secretary's Corner

The focus of this fall edition is on education in the field of Occupational Health PT. It is not only through education but also through research, communication, and development of quality standards of practice,that our Occupational Health SIG has been able to effectively shape the field of occupational health PT as we know it today and as it will evolve as a PT practice specialty. **YOU** can be a part of the growth of this exciting PT practice specialty. To join the Occupational Health PT SIG, you must be a current member of the Orthopaedic Section of the APTA. That's all there is to it!! There is no additional membership fee. The annual meeting is held at CSM each year. Also at that conference, the OHPTSIG sponsors an educational program on a pertinent occupational health PT topic and the "Hot Topics Forum," both of which have been extremely well received by the OHPTSIG and Orthopaedic Section membership, in addition to those professionals who wish to expand their knowledge base in this area. Participation in the OHPTSIG is easy, just volunteer to be on a committee. We **NEED** your knowledge, expertise, and participation, so join the OHPTSIG **NOW**!! For more information on OHPTSIG membership, contact Tara Frederickson at the Orthopaedic Section, APTA, Inc., e-mail orthostaff@centuryinter.net, phone (800)444-3982, or Ed Barnard, OHPTSIG President, phone (702)746-0544, e-mail ebarnard@aspen,reno.nv.us.

Bobbie Kayser, PT, OHPTSIG
Secretary, Newsletter Editor, and
Publications Committee Chair

OAL Approves California's Landmark Ergonomics Regulation

The California Office of Administrative Law (OAL) approved the nation's first regulation governing ergonomics in the workplace. The regulation became effective July 3, 1997. California employers with 10 or more employees are covered.

The regulation applies to "a job, process, or operation where a repetitive motion injury (RMI) has occurred to more than one employee" in a 12-month period. The RMI must be caused (50% or more) by a repetitive job, process, or operation. "The employees incurring the RMIs were performing a job process or operation of identical work activity. Identical work activity means that the employees were performing the same repetitive motion task, such as, but not limited to, word processing, assembly, or loading."

In 1993, the California legislature passed a bill requiring that, by January 1, 1995, the Cal/OSHA Standards Board had to implement an ergonomics standard designed to prevent repetitive motion injuries. Public hearings created situations where there was standing room only and involved lively discussion for and against. The Board could not come to an agreement on the content of the standard, and the deadline passed.

The California Labor Federation (and others as well) filed suit to force promulgation of a rule, and ultimately the board was ordered to adopt a standard by December 1996, which it did. But the OAL, the state's administrative oversight agency, returned the standard in January of 1997 citing its lack of clarity. The Board had 120 days to address the concern for clarity, format, and terminology. In April, the Board resubmitted its revised ergonomics proposal to the OAL, and on June 3, the OAL approved the nations first ergonomic regulation.

The regulation requires employers to "establish and implement a program designed to minimize RMIs. The program shall include a worksite evaluation, control of exposures that have caused RMIs and training of employees." There has been ongoing disagreement between labor and business regarding the depth and content of the regulation. Business leaders have felt all along that it is too stringent and will be too costly to implement, and labor has felt that its "reactive" nature and lack of depth (for example, focusing solely on "repetition") is inadequate.

The regulation is very brief (barely 1½ pages) and certainly has "gray" areas. There is a "policy and procedure" manual out that Cal/OSHA has developed. It is currently in a draft form and is available for review from any local Cal/OSHA Consultation office. This will be the document that OSHA inspectors will use when inspecting a facility, and will be an important document when in final form.

So how will this impact physical therapists? Well, basically in two ways. First, if you are a California employer with 10 or more employees, you are covered by the regulation and must comply. The good news is that as a PT you'll have plenty of internal resources to do so. Who better to analyze the workplace and implement an effective training program? If you do not have the time, there are other PTs in the state that do. Several PTs in California are "certified ergonomists." Take advantage of your colleagues' talent. That brings me to the second way this may impact your business. It is an opportunity to expand your services. PTs have an excellent foundation of knowledge and expertise on which to build, in order to provide ergonomic and injury prevention services to the business world. Seize the opportunity!

Title 8
General Industry Safety Orders
SSection 5110, Ergonomics

Readopted by the Occupational Safety and Health Standards Board on April 17, 1997

Nonsubstantive "Clarity of Display" modifications submitted to OAL on May 16, 1997
Approved by OAL on June 3, 1997
June 3, 1997 News Release, IR#97-31

Add new Section 5110, Ergonomics to read:
Group 15. Occupational Noise and Ergonomics
Article 106. Ergonomics
Section 5110. Repetitive Motion Injuries

(a) Scope and application. This section shall apply to a job, process, or operation where a repetitive motion injury (RMI) has occurred to more than one employee under the following conditions:

(1) Work related causation. The repetitive motion injuries (RMIs) were predominantly caused (ie, 50% or more) by a repetitive job, process, or operation,

(2) Relationship between RMIs at workplace. The employees incurring the RMIs were performing a job process, or operation of identical work activity. Identical work activity means that the employees were performing the same repetitive motion task, such as but not limited to word processing, assembly, or loading,

(3) Medical requirements. The RMIs were musculoskeletal injuries that a licensed physician objectively identified and diagnosed, and

(4) Time requirements. The RMIs were reported by the employees to the employer in the last 12 months but not before July 3, 1997.

Exemption: Employers with 9 or fewer employees.

(b) Program designed to minimize RMIs. Every employer subject to this section shall establish and implement a program designed to minimize RMIs. The program shall include a worksite evaluation, control of exposures which have caused RMIs and training of employees.

(1) Worksite evaluation. Each job, process, or operation of identical work activity covered by this section or a representative number of such jobs, processes, or operations of identical work activities shall be evaluated for exposures which have caused RMIs.

(2) Control of exposures which have caused RMIs. Any exposures that caused RMIs shall, in a timely manner, be corrected or if not capable of being corrected have the exposures minimized to the extent feasible. The employer shall consider engineering controls, such as work station redesign, adjustable fixtures or tool redesign, and administrative controls, such as job rotations, work pacing, or work breaks.

(3) Training. Employees shall be provided training that includes an explanation of:

(A) the employer's program,

(B) the exposures which have been associated with RMIs,

(C) the symptoms and consequences of injuries caused by repetitive motion,

(D) the importance of reporting symptoms and injuries to the employer, and

(E) methods used by the employer to minimize RMIs.

(c) Satisfaction of an employer's obligations. Measures implemented by an employer under subsection (b)(1), (b)(2), or (b)(3) shall satisfy the employer's obligations under that respective subsection, unless it is shown that a measure known to but not taken by the employer is substantially certain to cause a greater reduction in such injuries and that this alternative measure would not impose additional unreasonable costs.

Note: Authority cited: Section 142.3 and 6357, Labor Code. Reference: Section 142.3 and 6357. Labor Code.

Submitted by:
Joanette Alpert, MS, PT, CIE, CPE,
OHPTSIG Education Committee,
Woodward, Alpert & Associates, Santa Ana, CA

Ergonomics Primer Released

Practical approaches for protecting workers from job related musculoskeletal disorders are highlighted in a new document from the National Institute for Occupational Safety and Health (NIOSH) released in May.

Elements of Ergonomics Programs: A Primer Based on Workplace Evaluations of Musculoskeletal Disorders outlines approaches that are commonly used for identifying, correcting, and preventing work related musculoskeletal problems. Through actual examples from 2 decades of NIOSH research and assistance, it also illustrates how these techniques can be tailored successfully for specific types of workplaces.

The primer describes seven basic steps for controlling work related musculoskeletal disorders. Brief summaries of past NIOSH studies show ways that various aspects of these steps have been put into practice in different work settings.

The primer also features a "toolbox" section that compiles checklists, surveys, illustrations, directories, lists of publications, and other information useful for adapting and applying the basic elements of a musculoskeletal protection program.

Copies of the booklet (NIOSH Publication No. 97-117) are available by calling the toll-free NIOSH information number, 1-800-35-NIOSH (1-800-356-4647).

California Ergonomics Regulations Now On The Internet

The California Ergonomics regulations, TITLE 8, GENERAL INDUSTRY SAFETY ORDERS, SECTION 5110, ERGONOMICS went into effect July 3, 1997. Ergoweb has posted a copy on the Internet. You can find it by going to http://www.ergoweb.com, then select "Reference Room," and then "Ergonomics Standards and Guidelines." There you will see the links to the final version.

Bobbie Kayser, PT
OHPTSIG Secretary

APTA Task Force Meets

The APTA Task force on Injury Prevention/Functional Capacity Evaluation Guidelines met May 2-5, 1997. Their review of the Functional Capacity Evaluation draft document was completed in late summer. The APTA's Board of Directors voted to fund a second meeting that was held in September of 1997. At this meeting, feedback from field review for the Functional Capacity Evaluation draft was reviewed and used to complete the Injury Prevention Guidelines. The members of this task force are as follows:

Scott D. Minor, PhD, PT (Chair)
Dennis Hart, PhD, PT

Susan Isernhagen, PT
Deborah Lechner, MS, PT
Rick Shutes, PT
Allen Wicken, MS, PT (APTA Staff Member)

Added for the second meeting:
Robert Wiersma, PT
Jan Richardson, PhD, PT
(APTA President and Board Liaison)

Submitted by:
Scott D. Minor, PhD, PT
Program in Physical Therapy
Washington University School of Medicine
4444 Forest Park Boulevard
Campus Box 8502
St. Louis, MO 63108
phone: (314)286-1432
e-mail: minors@medicine,wustl.edu

Summary Of Medical Literature On The Diagnosis Of Carpal Tunnel Syndrome

The following conclusions are supported by the body of medical literature available on carpal tunnel syndrome (CTS):

1. Night pain that is relieved by shaking out the wrist and hand is the most specific symptom for CTS.
2. The Hoffmann - Tinel sign was not developed for the detection of CTS and it is not a sensitive test for CTS. It is not recommended as part of the examination for CTS.
3. The square wrist is the most sensitive sign for CTS. An A-P to M- L ratio of 0.7 or greater has approximately a 70% sensitivity and specificity for CTS. It is recommended as part of the physical examination for CTS.
4. Thenar weakness has approximately a 68% sensitivity and specificity for CTS. Evaluation of thenar strength is recommended as part of the physical examination for CTS.
5. The Phalen sign or modified Phalen sign has approximately a 55% to 80% sensitivity and 80% specificity for CTS. Its absence does not exclude CTS. It is recommended as part of the physical examination for CTS.
6. The LaBan sign has a high sensitivity and specificity and is helpful for cases of chronic CTS with median motor nerve fiber involvement.
7. Hypesthesia in the median nerve destruction of the hand has a sensitivity of about 50% and a specificity of over 80% in cases of CTS. Light touch and pinwheel sensibility are recommended as part of the physical examination for CTS.
8. Two point discrimination and the tourniquet test are not very sensitive for CTS and the tourniquets test can have a high false positive rate.
9. The gold standard for the diagnosis of CTS remains nerve conduction studies of the motor and sensory fibers of the median nerve. Sensory nerve-to-nerve comparisons have reported sensitivities and specificities of about 90%.

Thenar atrophy and weakness are usually only present in advanced cases of CTS. Sensory complaints noted by history often cannot be confirmed by examination in early cases of CTS. Physical signs are frequently absent in early CTS. No sign is reliable more than about two thirds of the time and the best of these include a square-shaped wrist and thenar weakness NOT the commonly documented Tinel and Phalen signs.

The diagnosis of CTS should be suspected on the basis of presenting symptoms and risk factors and confirmed by electrodiagnostic evaluation of the median nerve. Nerve conduction studies objectively document median nerve dysfunction with the highest sensitivity and specificity. They remain the gold standard for the diagnosis of CTS.

Submitted by Mark Kerastan, PT
Written by Bill Hennessy, MD, Pennsylvania Physical Medicine, Inc.

Membership in the Occupational Health SIG is open to any member of the Orthopaedic Section. To join, simply contact Tara Fredrickson at the Section Office, 1-800-444-3982.

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FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

FASIG CHAIR'S REPORT

Dear FASIG members:

It is hard to believe that the 1998 CSM in Boston is rapidly approaching. Our Educational Committee Chairman, Steve Reischl, has been burning the midnight oil in order to put the finishing touches on what should prove to be another exciting programming day for the FASIG. Our itinerary will include the following topics and speakers:

Friday, February, 13th, 1998

The Hallux-1st Metatarsal: Kinematic Analysis and Rx
Speakers: Deborah Nawoczenski, PhD, PT
Judith Baumbauer, MD

Foot and Ankle Nerve Entrapments: Unusual Clinical Presentations
Speaker: Mike O'Donnell, DPT, OCS

Sinus Tarsi Syndrome: A Misdiagnosed Foot Pathology
Speaker: Steve Baitch, PT

Achilles Tendon Repair: Traditional Management vs. Early Motion
Speaker: Jane Gruber, PT, OCS

Saturday, February 14th, 1998

Early Saturday morning, Chairman of the Practice Act Committee, Joe Tomaro, MS, PT, ATC, will lead an open discussion involving the second draft of terminology concerning foot and ankle biomechanics. This important session will hopefully lead to better communication and consistency among the various specialties within our profession.

This session will be preceeded by the FASIG Business Meeting, including elections for the Vice Chairman.

On a more serious note, it has come to my attention that increased membership is needed in order for our special interest group (SIG) to maintain its status as a viable entity of the Orthopaedic Section. If you are a member of the Orthopaedic Section, I encourage you to join the FASIG. Keep in mind that there is no charge to join this SIG if you are presently a member of the Orthopaedic Section.

Once again, as Chairman of the FASIG, I urge you to continue your membership with our SIG, and if you are not a member, that you will consider becoming a member of the FASIG. It is imperative that we, as physical therapists, continue our professional growth in areas of subspecialty, regardless of the external forces that are acting upon us.

I look forward to working with you in the future and hope to see you in Boston in February for the CSM meeting.

Best regards,
Stephen P. Baitch, PT
President, FASIG

Orthoses Material Selection
Am I making the right choice for my patients?
By Stephen P. Baitch, PT

Probably one of the most difficult decisions clinicians must make regarding the use of orthotics is the type of material we select for our patients. However, there are a few guidelines one can implement in order to make the selection process a bit easier.

AGE: The general rule is, the older the patient, the less rigid the material. Children, for instance, have a high tolerance for rigid materials, such as polydor and carbon graphite. They are extremely comfortable in the rigid orthotics and also receive the benefit of the much needed maximum control. The tolerance factor for rigid orthotic materials does tend to decrease with the aging process. After the age of 55 or 60, semi-rigid orthotics may be more appropriate. These materials may include high density polypropylene or semi-rigid carboplast materials. By the age of 65 or so, accommodative materials such as plastote or aliplast open-cell materials may be more suitable to provide cushioning and redistribute weight. Remember, this is a general rule and one must consider all other criteria when making decisions.

FOOT TYPE: A hypermobile flexible foot that is abnormally pronated, generally responds well to rigid materials. It is important to note, however, that the patient must

have adequate muscle strength in order to actively supinate the midtarsal and subtalar joint along with the supinatory force created by the rigid orthotic. If this is not the case, the patient will find the orthotic intolerable. This is especially true in situations involving posterior tibial tendon ruptures.

A rigid plano-valgus foot type, such as the case of a rheumatoid arthritic foot or a status-post arthrodesis procedure, may respond better to an accommodative orthotic, especially in feet that display bony prominences, such as subluxed metatarsal heads or base of the first metatarsal. These are cases however, that do respond favorably to rigid materials when the proper prescription variables are used to accommodate for bony prominences and lack of subtalar joint motion.

A flexible cavus foot type that contributes to increased lateral instability of the foot, performs optimally with rigid materials due to the ability to lock the midtarsal joint, thus preventing compensatory subtalar joint supination and midstance pronation. A rigid cavus foot type with a high forefoot valgus deformity may also have difficulty tolerating a rigid orthotic material. Therefore, some clinicians prefer to initiate treatment with a soft or semirigid orthotic and progress to a rigid material if necessary.

FOOT & ANKLE SPECIAL INTEREST GROUP OFFICER LISTING

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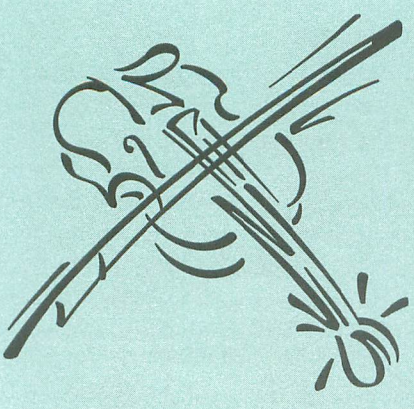

Performing Arts

SPECIAL INTEREST GROUP **ORTHOPAEDIC SECTION, APTA, INC.**

The PASIG Executive Committee recently sent a newsletter to all of its members, both Orthopaedic Section and non-Orthopaedic members, with a plea to join us officially. Much of the following is a recap of that newsletter.

MEMBERSHIP DRIVE

A number of physical therapists currently in the PASIG are not members of the APTA Orthopaedic Section. Most of our communication throughout the year is in *Orthopaedic Physical Therapy Practice* (known as *OP*), the newsletter of the Orthopaedic Section. Unless you are a member of the Orthopaedic Section, you do not receive this newsletter, nor do you have voting privileges in the Performing Arts Special Interest Group or Orthopaedic Section. Currently the PASIG's membership numbers are dangerously low. If we do not maintain a minimum of 2% (200) of the Orthopaedic Section members, we will lose our sponsorship as a SIG. If you believe in the importance of this SIG, for its programming, education, and networking resources, please support us! If you are already an Orthopaedic Section member, get a friend to join or sponsor a student. The first 50 new members with receive a free PASIG directory, a listing of PTs throughout the United States who support the performing arts. This directory allows us to better network with each other as well as guide performers to PTs when they go on the road.

Don't let the Special Interest Groups Dissolve!!

All special interest groups within the Orthopaedic Section must retain at least 200 Orthopaedic Section members on their membership lists in order to stay active. We want to continue to offer special interest group members the great programming and networking that these groups provide.

Be sure to sign up! Send or fax your special interest group(s) membership forms to the Orthopaedic Section as soon as possible!

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (____) _____ Fax: _____

E-mail Address: _____

Special Interest Groups: (Please check all that apply)

☐ Occupational Health ☐ Performing Arts

☐ Foot & Ankle ☐ Pain Management

OK to put work address in the PASIG Directory?

☐ Yes ☐ No

Return to: Orthopaedic Section, APTA, Inc., 2920 East Avenue South, La Crosse, WI 54601, 800/444-3982, FAX: 608/788-3965

UPDATE YOUR MEMBERSHIP INFORMATION

As you renew your APTA and Orthopaedic Section membership dues, please send an updated copy of your name and address to Tara Fredrickson. We will publish another PASIG directory in 1998 and need to have it current! Please include the address and phone number of the place where you practice, and your particular specialty, if you have one, as PASIG members may seek your assistance for traveling performers, etc.

PROGRAMMING FOR CSM '98

Please take a moment and look at next years CSM programming for the Performing Arts SIG. We have joined efforts with the Hand Section and the Foot and Ankle SIG to create two joint programs that I feel will be both dynamic and informative. In both cases traditional lecture will be supplemented with live demonstrations of evaluation and treatment of dancers or musicians. Additionally, at the end of the program, all the speakers will sit on a panel and respond to two case studies presented to them.

In addition to the above, we are responding to the requests of membership asking for guidance and encouragement regarding clinical research in the performing arts. To that end, we are presenting a workshop as outlined below.

Looking forward to February.
Marshall Hagins
Vice President and Program Chair PASIG

CALL FOR NOMINATIONS

Two officers on the PASIG Executive Board are up for re-election this year, Vice President and Secretary. The Nominating Chair, Marika Molnar, is now accepting nominations for these two positions. All nominees must be members in good standing with the Orthopaedic Section of the APTA. Nominations are due by close of business (EST) on October 31, 1997. Nominations should be sent to Marika Molnar, PASIG Nominating Chair, c/o Westside Dance Physical Therapy, 2109 Broadway, Suite 204, New York, NY 10023.

Vice President: Assumes the duties of the President in the event that he/she is unable to serve and/or attend scheduled meetings. The Vice President is a voting member of the Executive Board, and is currently responsible for coordinating the educational programming for national meetings. Term: 2 years.

Secretary: Records the minutes for all PASIG membership and Executive Board meetings, carries out all official correspondence on behalf of the PASIG, including mailed notifications of all meetings and elections and notices specifically requested by the PASIG Executive Board. The Secretary is a voting member of the Executive Board, and is currently responsible for coordinating all PASIG newsletters. Term: 2 years.

If you have any questions, please contact Marika Molnar at 212 787-0390.

PROGRAMMING CSM '98

Friday, February 13, 8:00-12:30
Upper Quadrant Evaluation and Treatment of the Musician
Level: Intermediate

8:00-8:30 Brent Anderson, PT, OCS	Epidemiology of Upper Quadrant Injuries in the Musician
8:30-9:15 Jeff Stenback, PT	Onsite Clinical Evaluation and Treatment of Two Musicians
9:15-10:00 Michael Charness, MD	Ulnar Neuropathy in Musicians
11:00-12:00	Exhibit hall break
11:00-11:45 Nancy Byl	Treating the Neural Consequences of Repetition on Musicians and Keyboard Users
11:45-12:30	Panel - two case study presentations

Friday, February 13, 1:00-2:30
Research Workshop on Physical Therapy for Performing Artists

Single Subject Research Design and Options for Data Analysis and Manuscript Preparation

Nancy Byl, PT, PhD — Jennifer Gamboa, MPT
Phyllis Browne, PT — Robert Turner, PT

Saturday, February 14, 12:30-5:00
Foot and Ankle Problems of the Dancer
Level: Beginner

2:00-2:15 Marshall Hagins, MA, PT	Introduction to Occupational Stressors of the Dancer
2:15-3:00 Jennifer Gamboa, MPT	Epidemiology and Assessment of Foot and Ankle Injuries of Dancers
3:00-4:00 Lynn Medoff, PT	Treatment of Foot and Ankle Injuries of Dancers
4:00-4:45 Lew Schon, MD	Imaging and Surgical Treatment of foot and Ankle Injuries of Dancers
4:45-5:30	Panel - two case study presentations

PASIG RESEARCH COMMITTEE SURVEY

We are starting to plan for the implementation of prospective research studies at multiple sites. Right now we are asking you to write down the most common problems you see in your performing arts clientele as well as any ideas you may have on the treatments you have found to be most effective. Also please let us know if you are particularly interest in participating in a multi-site study that will begin on frequency and distribution of injuries, effectiveness of treatments, and rates of reinjury.

Please take a few minutes to fill out the survey below and mail it to Jennifer Gamboa, MPT, PASIG Research Chair, c/o Body Dynamics Rehab Services, 3808 Wilson Blvd., Arlington, VA 22203.

PASIG RESEARCH COMMITTEE SURVEY

Name: _____

Address: _____

Phone Number: _____

Performing Arts Clientele: (Please circle)

Dancer (Style: _____) Musician (Instrument: _____)

Vocalist Gymnast Figure Skater Other: _____

Common Injuries: _____

_____

Treatment Interventions (specific to injuries listed above): _____

_____

Interested in Participating in a Multi-Site Study: (Please circle)

Very Interested Moderately Interested Not Interested

PLEASE MAIL BY NOVEMBER 28, 1997.

MENTORSHIP

Recently I spoke with a PASIG member who wanted to find out what is required of a mentor. I believe there are a variety of ways that a mentorship relationship can evolve. The most formal one is that of a "clinical affiliation" for a PT or PTA student. Another is a "visiting affiliation" in which a PT or PTA spends time with a mentor observing and learning about their work. A third way is to serve as a research advisor to PTs, PTAs, and students. The least formal is guidance on resources, references, and further education; discussion of articles, clinical problems, and issues as the mentoree seeks or the mentor offers it. All levels can be extremely rewarding to both individuals. If you have had the privilege of a rewarding relationship with a mentor, give back to someone else. Share what you have learned and experienced. Get involved at either or both ends of the mentor relationship. Let the PASIG know if you'd like to participate.

Shaw Bronner PT, MHS, OCS
PASIG Secretary

PASIG EXECUTIVE COMMITTEE

President:	Brent Anderson, PT	
	305 529-0023	FAX: 305 284-4534
Vice President:	Marshall Hagins, PT	
	718 488-1489	FAX: 718 780-4524
Treasurer:	Jennifer Gamboa, PT	
	703 528-3980	FAX: 703 528-3980
Secretary:	Shaw Bronner, PT	
	212 752-4021	FAX: 212 752-4029

PASIG COMMITTEE CHAIRS

Bylaws: Enid Woodward, PT
Education-Programming: Marshall Hagins, PT
Nominating: Marika Molnar, PT
Practice: Shaw Bronner, PT
Public Relations-Membership: Brent Anderson, PT
Research: Jennifer Gamboa, PT
Website: Nick Quarrier, PT
Please find the 5-year list of goals of the PASIG Committees on the following page.

PASIG Objectives

Committee	1 Year	3 Years	5 Years
Education/Programming (Standing) Chair: Marshall Need: 3 people	•Develop educational programs to support development of clinical research	•Incidence, etiology, assessment, and treatment of most common performing arts injuries •Develop educational programs for community outreach and performing arts practice development	•Develop educational programs to fulfill the standards established by the practice committee for performing arts specialists
Bylaws (Standing) Chair: Enid Need: 2 people	•Revise Mission Statement		
Practice (Standing) Chair: Shaw Need: 2 people	•Develop Dance/Music Specific Terminology Glossaries		•Establish practice guidelines for performing arts specialists (clinical mentorship/fellowship)
Nominating (Standing) Chair: Marika Need: 2 people	•Organize nomination and election of Vice President and Secretary for 1998		
Research (Special) Chair: Jennifer Need: 3 people	•Identify areas of need for research •Establish a support network for design and implementation of research		•Actively promote and support the public presentation of clinical research 3 to 5 times per year
PR/Membership (Special) Chair: Brent Need: 3 people	•Increase membership by 5% •Contact people with other professional organization	•Increase membership by 5% •Poster and/or brochure •Press kit/newsclips to additional magazines	•Increase membership by 5%
Website Committee (Special)	•Mechanism for maintaining and updating website •Newsletter •Abstract Calls •Changes in Committee		
Mentorship/fellowship (Special)			

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

President's Message

PAIN SEVERITY

"HOW BAD IS THE PAIN?"

Pain is the response to noxious stimulation or inflammation. The International Association for the Study of Pain (IASP) definition of pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage and described in terms of such damage." This actual or potential tissue damage is nociception and is caused by the release of bradykinins, serotina, protons, and other endogenous agents. Nociceptor (afferent nerve fibers) such as C Fibers, A-delta, and A-beta fibers have receptor sites peripherally or on organs that pick up the endogenous agent's data and transmit this data to the spinal cord and up to the brain. The brain receives this data and disseminates it to the limbic system, thalamus, and/or sensory cortex, but what determines how severe the pain response is?

Melzack (1) did a study of women with labour pains. There is a specific beginning and ending to this type of pain and as with all pain, it is significantly variable. Melzack found there was more pain in mothers:

A. whose babies were heavier,
B. when the mother was heavier,
C. who gave birth during the day,
D. lacked previous pain experience (no coping mechanisms), and
E. were horizontal rather than vertical (sitting).

The results were obtained by the use of the McGill pain questionnaire (MPQ) (Fig 1). These scores were compared to other MPQ pain sores and a pain rating was obtained (Fig 2). By comparing labour pain, clinical pain syndrome, and pain after accidents the severity of a patients pain can be better understood. The MPQ measures specific times of severity based upon description of pain. The day-to-day changes of pain may be measured with a visual analog questionnaire (Fig 3).

Just how severe is your patient's pain? It is subjective to that patient only. With the pain rating index (PRI) or an analogue scale, you as the clinician can better understand the severity of a patient's pain and resultantly provide an effective treatment program.

REFERENCE

1. Melzack R. Labour pain as a model of acute pain. *Pain.* 1993;53(2):117-120.

Tom Watson, MEd, PT, FAAPM
President, Pain Management SIG

The PAIN SIG wants YOU!!! PTs and PTAs. The role of the therapist in pain treatment/management is in flux. New discoverys and treatments are occuring constantly. If you treat pain JOIN TODAY. Call Tara at the Orthopaedic Section office.

A bibliography on pain treatment/management is available by calling the Orthopaedic Section. If you have pertinent references please call and add them.

1998 CSM Programming

The PAIN SIG program at CSM Boston 1998 is "Functional Outcomes of Pain Management" on Friday at 8:00-10:00 AM . The speakers are Harriet Wittink MS, PT, OCS and Daniel Carr, MD, FACPM. This will be an exciting and timely presentation. Also Harriet has co-authored with Terry Michaels and published a book geared towards PTs on chronic pain.

The executive committee members of the PAIN SIG are:

President - Tom Watson, PT
619-462-9285

Vice- President- Maureen Simmonds, PT
713-794-2070

Secretary - John Garzione, PT
607-334-8770

Education Program- Joe Kleinkort, PT
916-335-5395

Liaison - Gaetano Scotese, PT

PLEASE CALL IF YOU WANT TO DISCUSS PAIN OR ANY ITEM RELATED TO THE PAIN SIG.

346 TEXTBOOK OF PAIN

SHORT-FORM McGILL PAIN QUESTIONNAIRE

RONALD MELZACK

PATIENT'S NAME: _____ DATE: _____

	NONE	MILD	MODERATE	SEVERE
THROBBING	0)	1)	2)	3)
SHOOTING	0)	1)	2)	3)
STABBING	0)	1)	2)	3)
SHARP	0)	1)	2)	3)
CRAMPING	0)	1)	2)	3)
GNAWING	0)	1)	2)	3)
HOT-BURNING	0)	1)	2)	3)
ACHING	0)	1)	2)	3)
HEAVY	0)	1)	2)	3)
TENDER	0)	1)	2)	3)
SPLITTING	0)	1)	2)	3)
TIRING-EXHAUSTING	0)	1)	2)	3)
SICKENING	0)	1)	2)	3)
FEARFUL	0)	1)	2)	3)
PUNISHING-CRUEL	0)	1)	2)	3)

NO PAIN — WORST POSSIBLE PAIN

PPI

0 NO PAIN _____
1 MILD _____
2 DISCOMFORTING _____
3 DISTRESSING _____
4 HORRIBLE _____
5 EXCRUCIATING _____

Fig 1

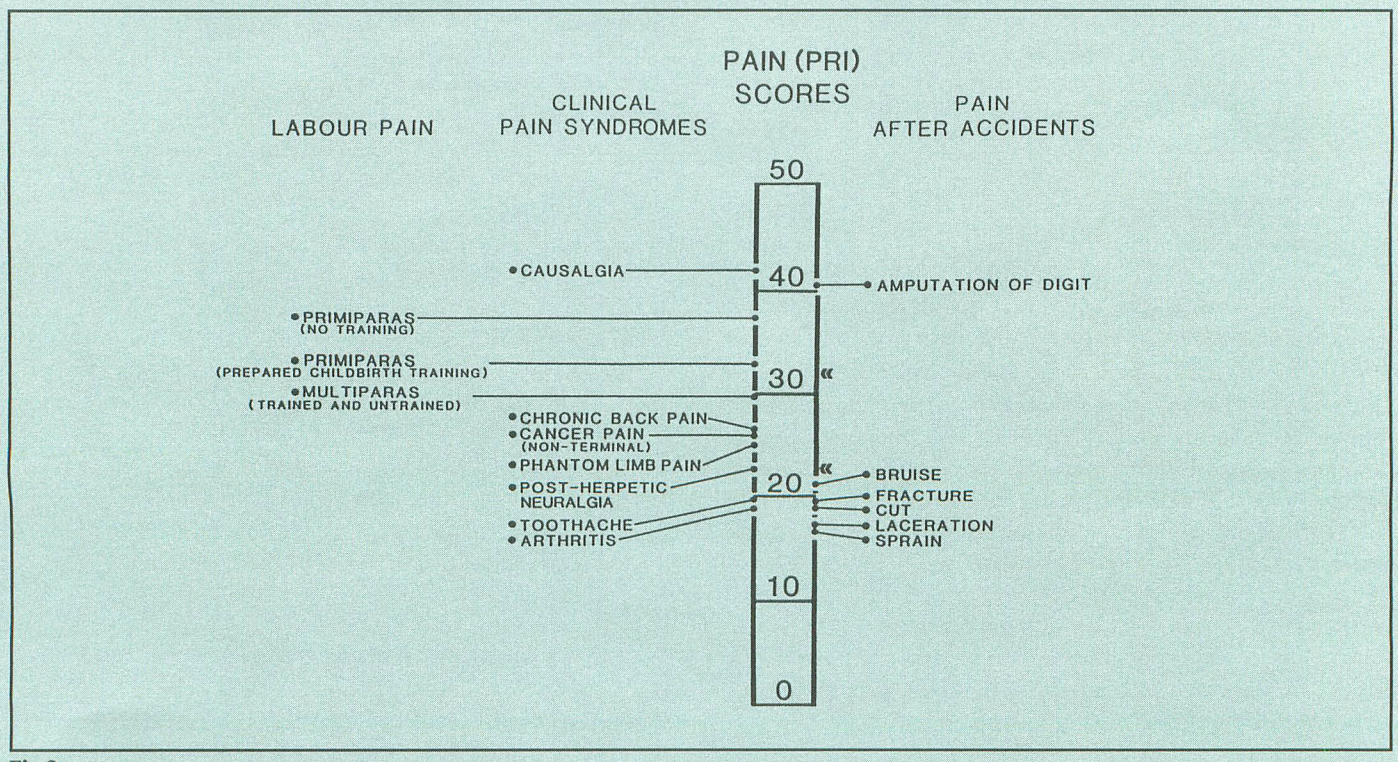

Fig 2

Watson

Physical Therapy for Pain

PAIN QUESTIONNAIRE

NAME: _____

To help us further evaluate your progress, please mark your present intensity of pain and frequency of symptoms. This form will be used for your benefit and statistical information.

I UNDERSTAND THE ABOVE STATEMENT,

SIGNATURE _____

	INTENSITY	FREQUENCY	ACTIVITY LEVEL
	0 - No Pain 1 - Little Sore 2 - Sore 3 - Ache 4 - Strong Ache 5 - Actively Hurts 6 - Almost Crying 7 - Crying 8 - Intolerable 9 - Hit Head on Wall 10 - Jump Off Bridge	0 - None 1 - Rare, Once/Week 2 - 2 to 3 Times/Week 3 - Seldom, 3 Days/Week 4 - 4 of 7 Days 5 - Daily, 3 Hours, With Movement Only 6 - Daily, 3 to 5 Hours 7 - Daily, 5 to 8 Hours 8 - Daily, 8 to 12 Hours 9 - Daily, 12 to 20 Hours 10 - Daily, 24 Hours, No Sleep	0 - No Restrictions 1,2 - Vigorous Activity 3 - Usual & Customary 4 - Prolonged Walking, Standing, Driving (1 hour or more) 5 - Moderate Walking, Standing, Driving (30 minutes) 6 - Minimal Walking, Standing, Driving (15 minutes) 7 - Housebound 8 - Restricted, Bed & Chair 9 - Bed & Bathroom Only 10 - Bed Only
Date/Initial	INTENSITY	FREQUENCY	ACTIVITY LEVEL
1._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
2._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
3._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
4._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
5._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
6._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
7._____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

*** What percentage of improvement do you feel since your initial treatment?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

pain ques

ORTHOPAEDIC PHYSICAL THERAPY HOME STUDY COURSE JULY ~ DECEMBER '97

HSC 97-2 TOPIC:
THE ELBOW, FOREARM, AND WRIST

Proposed Topics and Authors

Disorders of the Wrist and Distal Radioulnar Joint
Carol Waggy, PhD, PT, CHT

Gymnastic Injuries to the Elbow, Forearm, & Wrist
Jill Troisi, BS, PT

Elbow & Forearm Fractures
Rebecca Saunders, PT, CHT and Jane Schmidt, PT, CHT

Peripheral Nerve Compression Neuropathies
Carolyn Wadsworth, MS, PT, OCS, CHT

Reflex Sympathetic Dystrophy Syndrome
Susan Stralka, MS, PT and Laura Chunn, PT

Athletic Injuries about the Elbow
Lori Thein Brody, MS, PT, SCS, ATC

Objective:
The objective of the Orthopaedic Section Home Study Course is to provide the physical therapist with a distance learning experience on issues relating to assessment, treatment and research as these topics apply to the patient with musculoskeletal problems.

Subject Code: Orthopaedics

Instructional Level: Various

Editor: Carolyn Wadsworth, MS, PT, OCS, CHT

Registration & Fees:

Register by June 6, 1997; Limited supply available after this date.

$150 Orthopaedic Section Members
$225 APTA Members
$300 Non-APTA Members

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Please call the Section office at 1-800-444-3982 for further information.

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REQUEST FOR PROPOSALS
ORTHOPAEDIC SECTION, APTA

CLINICAL RESEARCH GRANT PROGRAM

Purpose: The Orthopaedic Section must support its members by funding studies designed to systematically examine orthopaedic practice issues. The purpose of this grant program is to address the urgent need for clinical research in orthopaedic physical therapy.

Targeted Recipients of the Grant Program: The grant program is designed to provide funding for any Orthopaedic Section member who has the clinical resources to examine a well-defined practice issue, but who needs some external funding to facilitate the completion of a clinical research project.

Studies Eligible for Funding: The four types of studies that will qualify for funding are studies that: *1)* examine the effectiveness of a treatment approach on a well-defined sample of patients with orthopaedic problems; *2)* examine patient classification procedures for purposes of determining an appropriate treatment; *3)* further establish the meaningfulness of an examination procedure or a series of examination procedures used by orthopaedic physical therapists; and *4)* examine the role of the orthopaedic physical therapist in the health care environment. Authors must stipulate which purpose their grant is designed to address.

Categories of Funding: Funding will be divided into two categories:

Type I Grant Funding: $1,000.00 maximum

This program is designed for therapists who require only a small amount of funding for a project or are in the process of developing a project. The funds in this program will be used for pilot data collection, equipment, and consultation.

Type II Grant Funding: $5,000.00 maximum

This program is designed for therapists who are ready to begin a project but need additional resources. The grant may be used to purchase equipment, pay consultation fees, recruit patients, or fund clinicians. Clinicians receiving funding from this program will be expected to present their results at CSM within 3 years of receiving funding. Recipients will receive $300 to allay costs associated with presenting at CSM.

Criteria for Funding: Type I Grant

—A specific and well-defined purpose that is judged to be consistent with the four types of studies eligible for funding and described above

—The sample studied must include patients. For studies examining the role of the orthopaedic physical therapist in the health care environment, the sample studied would be therapists involved in the delivery of care

—Priority given to projects designed to include multiple clinical sites

—Priority given to studies examining treatment effectiveness

—Institutional Review Board approval from participating site(s) and letter of support from facility(ies) participating in the study

—Principal investigator must be an Orthopaedic Section member

—Priority given to projects that are currently not receiving funding

—The funding period will be 1 year

Criteria for Funding: Type II Grant

Criteria are the same as listed above for the Type I grant plus the following:

—Evidence of some pilot work

—The funding period will be 1 year, renewable for up to 3 years, if judged to be appropriate

Determination of the Award: Deadline for submission of grant proposals is **December 1, 1997**. Each application should include one original and six copies of all material. The Grant Review Committee will review and evaluate each eligible application. A total of $30,000 is budgeted for grants each year (five at $1,000 and five at $5,000). All applicants will be notified of the results by March 1, 1998.

To receive an application, call or write to:

Clinical Research Grant Program
Orthopaedic Section, APTA, Inc.
2920 East Avenue South
La Crosse, WI 54601
800/444-3982

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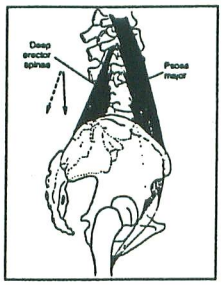

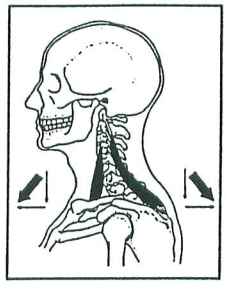

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